		For State Registrar	State of M	Maryland / Dep Co		of Health ar of Death		giene Reg. No. 20	05 33001
Physic		1. Decedent's Name (First, Middle, Las Catherine Gertru					2. Date of Dea Month Septemb	Day	Year 2005 4:00a M
/Medi Exami		4a. Facility Name (If not institution, give 1073 Plum Creek	street and number Drive	er)	Crov	wn, or Location of D	Death	4c. County Anne	Arundel
Funeral Director		5. Social Security Number 6. S 577–24–8643	ex 7 □M 24© F	Age (In yrs. last birthda 82 Yrs.		Year If Under 24 Days Hours	Hrs. 8. Date of Birt Min. (Month, Date of March 5	, Year) , 1923	9. Birthplace (State or Foreign Country) Washington, D.
Maryland I-f show lied at	tor	10a. State 10b. County Maryland Anne Aru	ndel	10c. City, Town or Crownsv:					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ith the or 28s	Sirec	10e. Street and Number			10f. Zip C			10g. Citizen of	
BAITIMORE, IMARYIBING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exprired must be notified at	by Funeral Director	1073 Plum Creek I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	x No	3. Was Deceder If Yes, specify		n? (Specify Yes or No- Puerto Rican, etc.)	Bla	ce - American Indian, ck, White, etc.
A I A I D-UUDO ed within 72 hours af giene "naturel", or er then "naturel", or the Medical Exami	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4)	(Gi	a. DO NOT use	doné during most o retired)			Business/Industry
d be filed wental Hygier ked other the	To Be Cor	12 17. Father's Name (First, Middle, Last, John Keese)		Secr		s Name (First, Middle,		n Red Cross
Widtyldid nd 2 should be file lth and Mental Hy 27 is marked oth traumatic event	F	19a. Informant's Name/Relationship (Linda O'Dea/Daugh					or Rural Route Number		
SAITIMOTC , permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specie	Removal from Sta	20b. Place of Dis	sposition (Name crematory or oth	of er place)	Date /22/05	20c. Location	- City or Town, State
Daltin permit. P Departme Importen any injury		21. Signature of Funeral Service Lice		C I	22. Name and Fort Li	Address of Facility	neral Home	N-1410-000-00-00-00-00-00-00-00-00-00-00-00-	
Physiciar /Medica Examine		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Meta Due to (or	astatic Lun as a consequence of):			ardiac or respiratory a	niest,	Approximate Interval Between Onset and Death 6 months
death certificate be executed ettending physician and et or use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	as a consequence of):					
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birt	ome of pregnancy h 2 Fetal death nt at time of death on	3 □Ectopic pred				ate of delivery lonth Day Year
dS, F.C uires that the signed by th	b	Part II. Other significant conditions Congestive Hear			e underlying cau	use given in Part I.		tobacco use cor Yes 2 □ No	ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Vital Records, sicien: The law requires t certificate has been signe irector, page 2 should be	Completed						24a. Was auto perfo 1 Yes		. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
OT VITAL Physicien: 1 r this certifical	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No		patient 2 ER/Outpa		Other: 4 Nur	of Death Check on sing Home 5X Resi		
SION tending leath. lor: After the fune	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on	Injury 28b. Tim Intu	M M	ic. Injury at Work? 1 Yes 2 N	lo		nber or Rural Route Number,
DIVISION To the Hospital or Attenwithin 24 hours after deal To the Funerel Director:		4 Homicide determined	building	g, etc. (Specify)			City or To	wn, State)	
To the Hospital or within 24 hours after To the Funerel Dir.	Aedical	(Check only 2 Medical Exa	mysician: 10 the das aminer: On the bas and manne	sis of examination and/o	or investigation,	in my opinion, death	h occurred at the time,	, date and place	e, and due to the cause(s)
To the comple	Σ	29b. Signature and title of certifier	Cl	lemo	5	D48101			ber 22, 2005
R (3)		30. Name and address of person who Donna G. Chamber	s, M.D.,	of death (Item 23a) (Ty 2002 Medic	rpe, Print) cal Park	way, Ste	350, Anna	polis,	MD 21401
	State strar	31. Date filed (Month, Day, Year) SEP 2 7 200	≱ . Re	gistrar's Signature	A				

			For State Registrar	State of M	larylan			t of He			ental Hy		2005	33	002
			1. Decedent's Name (First, Middle	, Last)							2. Date of De.	ath Da	y Year	3. Time	
	Physici /Medio		John Edward	Onyun			·						25, 2005	12:5	5 p M
	Examir		4a. Facility Name (If not institution		7)				ocation of	Death		4c.	. County of Death		
			3107 Edgewood					nsing	·	4 Bles			Montgom		
	Funeral Director		5. Social Security Number 577-01-8684	6. Sex 7. A 1 ■ 7. A	ge (In yrs. 89	last birthday) Yrs.	Months	Days	If Under 24 Hours	Min.	B. Date of Bin (Month, Da June 25	h y, Year) 5 , 1		oface (State otry) ingto:	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside	City Limits
	Maryl f sho	ō	Maryland Monto	7 O M O 3017	V.	onaina	t a n							1 □ Ye	s 218 No
	1he	rec	10e. Street and Number	gomery	K	ensing	10f. Zip	Code				10g. Cit	izen of What Cour	ntry?	
	3a or	Funeral Director	3107 Edgewood	Road				20895	<u>,</u>				USA		
	death ms 2	nera	11. Marital Status	12. Was Deceder		.S. 13.	Was Deced	ent of His	panic Origi	n? (Spec	ify Yes or No ican, etc.)	- T	14. Race - Americ		
9	or Ite	Ī	1 Never Married 2 Marri	Armed Forces ed MXYes 2 If Yes, Give			1 ⊡ Yes		Specify:	Pueno H	ican, etc.)	1	Black, White,		
93	irel',	d by	3 Widowed 4 □ Divorced	Year or Dates	: WWI	Ι		ZIJINO	Specify.				SpecifyWhit	e	
215-0036	within 72 hours after death with the Maryland ane. then "neturel", or items 23a or 28e-f show the Marical Examiner rust be neithful at	Completed	15. Decedent (Specify only highest			16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupat k done du	ion ring most d	of working	9	16b. K	ind of Business/In	dustry	
121	within ane. then	E	Elementary/Secondary (0-12)	College (1-4o	5+)			se retirea)					D l- *		
121	Hygie Hygie ther t		12 17. Father's Name (First, Middle,	ast)		В	anker	1	IS Mother	s Name	(First, Middle,	Maiden	Bankin	g	
and	ntail hed o	Be c	Clarence Alva	ŕ				'			ise Lav		Sumame)		
Maryland	12 should be filled within h and Mental Hygiene. 7 Is marked other then "treumatic event, Ite Max	2	19a. Informant's Name/Relationsl	-		19b. Mailir	na Address	(Street an					or Town, State, Zip	Code)	
Ma	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. ortent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show injury or other treumatic event, the Madical Examiner rival be neithed as 8.		John C. Onyun,				-						nsington		20895
ē,	Hea Hea Hea Hea Hea Hea Hea Hea Hea Hea		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	Se	ept.Da	^{te} 29	20c. Lo	ocation - City or To	wn, State	
30	age:	1	1 ☑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S)		9	rest O			- 1	200		ait	hersburg	. Mar	vland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre QDCs.		21. Signature of Juneral Service						- ,				me Inc	, mar.	, Lana
ñ	permit Depar Impor any in		(inshew)	J-Colo									me Inc r Spring	MD :	20001
8760,	law requires that the death certificate be executed Example as been signed by the attending physician and 2 should be detached for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arteric Due to (or a b. Due to (or a c. Due to (or a d.	s a conseq ensions a conseq	uence of): uence of):	erebr	ovaso	cular	Dise	ase				
9	artifice ing ph e as th	Med	IF FEMALE:												
O. Box	that the death certific ed by the attending pl detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	fdeath 3	Ectopic pro Other (sp.						23d. Date of delive Month	Day	Year
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying ca	ause given	in Part I.		23e. Did to	obacco u	use contribute to th	e cause of	death?
rd	w require been sig should b	edt	Alcoholism								101	es 🔏	No 3□Prob	ably 4]Unknown
Records,	0 2 0	Completed					-				24a. Was autop perfo		24b. Were auto prior to cor death?	npletion of	available cause of
Vital	icien: Th certificate rector, pag	Ö	25. Was case referred to medical						ne Diago o	of Dooth	1 □ Yes 'Check only o		1 🗆 Yes	2□ No	
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Dinna	tient 2 🗆	ER/Outpatier	nt 3 DO						6 □Other (Specify	·	-
of			27. Manner of Death	28a. Date of In		28b. Time of		8c. Injury a Work?	at		d. Describe h				
Ö	Attending F r death. sctor: After by the funer	atio	1 Natural 5 Pendin 2 Accident investig	ation	ay rear	Injury	М		s 2 No	0					
Division	tel or Atte s after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 289. Place of I	njury - At ho etc. (Specif	ome, farm, str y)	eet, factory	, office		28	If. Location (S City or Tox	Street an yn, State	d Number or Rura)	l Route Nui	mber,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the bes Exeminer: On the basis and manner:	of examina	wledge, death tion and/or in	n occurred a	at the time in my opir	, date and nion, death	place, ar occurred	d due to the	cause(s)	and manner as st d pface, and due to	ated. the cause(s)
	To t com	Σ	29b. Signature and title of dertifler		0		29c	. License r					te signed (Month,) E
,	140		1	M)	/			D#02				peb.	tember 26	, 200	
-	U-1 '		30. Name and address of person Alec Anders, I					nue,	#606,	Ken	singto	n, I	MD 20895		
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 7	32. Regis	trar's Signa	iture	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 35Tim of Death 3 25, 2005 **Physician** O'Dell September 4:59 Sheri Ann а /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7507 Alfred Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1943 West Virginia **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs. Director 235-64-4515 62 Feb. 16, Usual Residence of Decedent the Maryland wode 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner hast be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Silver Spring 28a-1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 7507 Alfred Drive or Itema 23a 20910 death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 € Never Married 2 Married White 1 ☐ Yes 21 No Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced natural Completed the Mudical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Direct Mail Elementary/Secondary (0-12) College (1-4or 5+) 5+ Writer/Journalist Fundraising filed injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental File marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If Iem 27 te marked c any injury or other traumatte. Theodore Edward O'Dell Mary Kaythryn Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Chapin/Personal Rep 7507 Alfred Drive, Silver Spring, MD 20910 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Sept. 26, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc ala 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 3 Weeks /Medical Due to (or as a consequence of) **Examiner** b. Non-Small Cell Lung Cancer Less than 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Months certificate be executed burial-transit Exami Due to (or as a consequence of) attanding physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 99 Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has page 2 autopsy performed? cartificate 1□ Yes 2¬No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 16 Natural 5 Pending after death. 1 Tes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 September 26, 2005

State

Registrar

10

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Vital

of

Division

Linda M. Burrell, 31. Date filed (Month, Day, Year)



30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

M.D.

ll mo

Physician Fligsboth Jone Orangesk	Reg. No 2005 33004 of Death 3. Time of Death
Fliggboth Inno Orangesk	
Medical Elizabeth Jane Glanczak Sept	ember 20, 2005 7:07 A M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital Frederick	Frederick
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date (Mor	of Birth 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	ch 9, 1927 Pennsylvania
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Frederick Brunswick	1 X Yes 2 ☐ No
10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
1201 Maple Terrace Lane 21716	United States
Maryland Frederick Brunswick 10e. Street and Number 10f. Zip Code 1201 Maple Terrace Lane 11. Marital Status 11. Never Married 2 Married 11. Never Married 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 11. Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes Armed Forces?) 14. Never Married 2 Married 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, e	tc.) 14. Race - American Indian, Black, White, etc.
(O = To I Never Married 2 Married 1 Yes 2 ⊠ No If Yes, Give 1 Yes 2 ⊠ No Specify: Year or Dates:	Specify: White
Total State 10b. County 10c. City, Town or Location 10c. City 10c. City 10c. City 10c. City 10c. City, Town or Location 10c. City 10	16b. Kind of Business/Industry
(Give kind of work done during most of working life. DO NOT use retired) Specify only highest grade completed (Give kind of work done during most of working life. DO NOT use retired)	
Nomemaker 12	Own Home
The state of the s	Middle, Maiden Sumame)
Otto Suther	**
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route 225 Tamarack Way Brunswi	
Jane Hartman / Daughter 225 Tamarack Way Brunswi 20a. Method of Disposition 20b. Place of Disposition (Name of Date	ck, Maryland 21716 20c. Location - City or Town, State
Septembe 1 Burial 2 SCremation 3 Removal from State Cemetery, crematory or other place) 4 Donation 5 Other (Specify) Frederick Crematory 23, 2005	r Emoderate Messal and
무 트립트	Frederick, Maryland er Funeral Homes, P.A.
1621 Opossumtown Pike	Frederick, Maryland 21702
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira shock, or heart failure. List only one cause on each line.	tory arrest, Approximate Interval Between
Physician Immediate Cause (Final disease or condition ASCVD	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions b.	
E Cause (Disease or injury	
The state of the s	
Ligate be seed that it is the provided and the provided a	
e elifica e elifica es para para para para para para para par	
YO USE TO SEE T	23d. Date of delivery
So to be compared to the property of the prope	Month Day Year
	Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
The law requirement of	. Was an 24b. Were autopsy findings available
The law age to page 2	autopsy prior to completion of cause of performed? death?
	Yes 2⊠ No 1 ☐ Yes 2⊠ No
25. Was case referred to medical examiner? 1 Yes 2 No	Residence 6 Other (Specify)
1 Impatient 2 ER/Outpatient 3 DOA Outs. 4 Nursing Home 5 To Pending 1 North North, Day Year) North Nor	cribe how injury occurred
O D d d d d d d d d d d d d d d d d d d	
28d. Des Date of Injury 28d. Des Date of Injury 28d. Des Date of Injury 3 28d. Des Date of Injury 4 28d. Des Date of Injury 5 28d. Des Date of Injury 4 28d. Des Date of Injury 5 28d. Des Date of Injury 5 28d. Des Date of Injury 6 28d. Des Date of Injury 7 28d. Des Date of Injury 8 28d. Des Date of Injury 9 28d. Des Date of Injury 8 28d. Des Date of Injury 9 28d. Des Date of Injur	ntion (Street and Number or Rural Route Number, or Town, State)
it is	In the cause(s) and manner as stated
29a. Certifier (Check only one) 29a Certifier (Check only one)	time, date and place, and due to the cause(s)
29b. Signature and true of Pertifier 29c. License number	29d. Date signed (Month, Dey, Year)
D0054731	September 27, 2005
Y TO THE TOTAL PROPERTY OF THE PARTY OF THE	
30. Nam and add ess of person who completed cause of death (Item 23a) (Type, Print)	
30. Nam and address if person who completed cause of death (Item 23a) (Type, Print) Cynthia J. Moorman, M.D. 198 Thomas Johnson Drive Freder: State Registrar 31. Date filed (Month, Day, Year) SEP 2 7 2005 32. Register's Signature	ick, Maryland 21702

			5	State of Maryland		nt of Health and		•	
			1 = For State Registrar			te of Death		A A A	33005
	Physic	an	1. Decedent's Name (First, Middle, La				2. Date of Death Month		3. Time of Death
	/Medi	cal	Hella V. O 4a. Facility Name (If not institution, gir		4h Cit	y, Town, or Location of Dea		24 2005 4c. County of Death	11:554
A 100 M	Examir		0 1	growal Medial		5.24	lisheny	Wicom.	100
-	Funeral		Social Security Number 6.4	Sex 7. Age (In yrs. la	st birthday) If Und	er 1 Year If Under 24 Hrs s Days Hours Min		9. Birthplac	ce (State or Foreign
煮	Director		234-26-1517 Usual Residence of Decedent	1□M 2 7 F 85	Yrs.			1919 SIMPS	SON W.VA.
	yland		10a. State 10b. County	10c. City,	Town or Location			t0d	d. Inside City Limits
	Ba-f et	ctor	MD. Wice	omico s	SALISBU)RY			Yes 2 □ No
	with th	Dire	10e. Street and Number			ip Code	10g	. Citizen of What Country	/?
	ne 23	eral	11. Marital Status	STREET 12. Was Decedent Ever in U.S		180 edent of Hispanic Origin? (5	Specify Yes or No-	14. Race - American	Indian
9	after o	Fu	1 Never Married 2 Marned	Armed Forces? 1 Yes 2 No If Yes, Give		edent of Hispanic Origin? (Secrety Cuban, Mexican, Puel	rto Rican, etc.)	Black, White, etc	c.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Exarignat must be notified at	Completed by Funeral Director	3 ☐Widowed 4 ☐ Divorced	Year or Dates:	TUYes	No Specify:		Specify: WHI	TE
15-	in 72 t	ojete	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Us (Give kind of v life. DO NOT	ual Occupation rork done during most of wo use retired)	orking 16	b. Kind of Business/Indus	stry
212	filed with Hygiene. Ither ther Int, the N	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSE			HOMEMAK	ER
	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai		
Maryland	should be nd Mental marked o	2		JTOSH				IT MEIN	
Ma	and 2 sho balth and I n 27 le mu		19a. Informant's Name/Relationship	(SPOUSE)	30218	ss (Street and Number or R	on Bridg		bury MD
ē,	if Health item 27 other tr		20a. Method of Disposition	20b. Pla	ace of Disposition (Nametery, crematory or	ame of		c. Location - City or Town	
imo	Pages nent of I ant: If it ury or of		1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	Inemoval from State		EMETERY 9-	30-05 PR	משטדעדימט	w. VA
Baltimore,	permit. Pages Depertment of Important: If i eny injury or o	3	21, Signature of Funeral Service Lice	982	22 Name	and Address of Eacility			•
100	202.0		23a Parti Enter the disease or con	dompoor C	SP 501 5	OWAY FUN	ZD. SALI	SBURY MO	
4	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Do not enter the inc	c cardia	ic or respiratory arrest,	ino	pproximate nterval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	mia /seps				
9 (4	Examiner		Sequentially list conditions.	b. aspirat	i'on par	eumonia			
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):	farction			
Ć,	ate be executed hysician and the burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or as a conseque	-d. 4((n{ ence of):	ariv.on			
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68 ×	The law requires that the death certificat sie has been signed by the attending phy bage 2 should be detached for use as the	Med	IF FEMALE:						
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1☐Live birth 2☐Fetal of	death 3 Ectopic			23d. Date of delivery Month Da	ay Year
P.O.	that the de ned by the a detached t	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5 C Other (s	греспу)			,
	es that igned b	by Pł	Part II. Other significant conditions	contributing to death but not result	ting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
ord	w require been sig should b	ted	uTI				1 ☐ Yes	2 No 3 Probabl	ly 4 Unknown
Records,	has be	Completed	atrial f.b	ail ation			24a. Was an autopsy	24b. Were autopsy prior to compl	y findings available letion of cause of
alF	ician: The lav certificete has ector, page 2		CHF				performed	1? death? No 1 ☐ Yes 2 ☐	□No
of Vital	Physician: this certifice ral director, p	To Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ E	R/Outpatient 3 D	Other	ath (Check only one)	2 Flori (2)	
	D 0 0		27. Manner of Death		28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	e 6 Other (Specify)	
sior	ne oat	catic	t Natural 5 ☐ Pending 2 Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n	M	1 ☐ Yes 2 ☐ No			
Division	al or Attendin setter death. I Director: Af d in by the fur	Certification:	3 Suicide 6 Could not be determined		ne, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	t and Number or Rural Ritate)	oute Number,
	To the Hospital or Attention 24 hours efter de To the Funeral Directe completely filled in by the		29a. Certifier 1 Certifying Pl	nysician: To the best of my know niner: On the basis of examination	ledge, death occurre	d at the time, date and place	e, and due to the cause	e(s) and manner as state	ad.
	he Ho in 24 t he Fu pletely	Medical	(Check only one) 2 Medical Example Medical Example (Check only one)	niner: On the basis of examination and manner stated.	on and/or investigation	n, in my opinion, death occi	urred at the time, date	and place, and due to the	e cause(s)
	with To t	Σ	29b. Signature and title of certifier	144	_	Oc. License number		Date signed (Month, Day	
	800		· //a	~ 100		0006213	U	9/24/200	5
	100		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	lealthway Dr.	Salishun	MD 218	04
	Sta		31. Date filed (Montis Epy 27) 6	32 Projetrar's Signatur			- 3(1)	1	- 1
3.0	Reaistr	ar		A State of the same of	The Man N				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Ruth Marie PRYOR Sept. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hagerstown
If Under 1 Year If Under 24 Hrs. 19839 Scott Hill Drive Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🕅 F Months Days Hours Min 89 19 1916 Maryland **Director** Sept. 214-09-1147 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 21 any ijury or other traumatic event, the Martinet. 19839 Scott Hill Drive 21742 <u>USA</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3X Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Law Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry C. Harrison Mary R. (unknown) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Pryor - Son 1418 S. Potomac Street, Hayerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 19/30/05 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Mile Approximate Interval Between Onset and Deat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 100 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier completely (Check only one) To the 29b. Signature an 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Pri) 30. Name and address of person with 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 29 2005 Registrar

Registrar

State

2 8 2005

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28e-f show Examiner must be notified at

'natural', or

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permit. Pages 1 and 2 should be file Cepartment of Health and Mental Hy, Importent; if Item 27 is marked other any Injury or other treumatic

Physician

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the attending physician and ched for use as the burial-transit

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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Certification: To

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death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cert	ificate of	Death	,	Reg. No.		
	Physici	212	1. Decedent's Name (First, Middle, La.	st)					2. Date of De		20,0,5	3. Pine of Death
	/Medic		JACQUELINE VIRGINI						SEPTEMBE		2005	10:30 OAW C
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o		eath		County of Death	1
_			19705 OLNEY MILL ROAD 5. Social Security Number 6. S	ex 7 Age	In yrs. last bi		BROOKEVILI If Under 1 Year		Hrs. 8. Date of Bir		rgomery	alaa (Chan a Carrin
	Funeral Director			□M 2⊠F	69	Yrs.	Months Days		JANUARY	ay, Year)	Cou	place (State or Foreign intry) YLVANIA
	land ow		10a. State 10b. County	1	Oc. City, Tow	m or Loc	ation					10d. Inside City Limits
	Mary F-1 sh	to	MARYLAND MONTGOMERY	7	BROOKEV	LLE						1 ☐ Yes 2 🖾 No
	or 28g	Directo	10e. Street and Number	-	211001111		10f. Zip Code			10g. Citize	en of What Cou	intry?
	23e		19705 OLNEY MILL ROAD				20833		15	U.	S.A.	
	tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of H Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.))- 14	I. Race - Ameri Black, White	
2-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "naturel", or Items 23e or 28e-f show event, the Medical Examinar must be incilial at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ∐Yes 2 ဩNo If Yes, Give Year or Dates:		1	☐Yes 2፟ØNo				Specify: WH]	
ה	72 h	etec	15. Decedent's Ed (Specify only highest gra		16a	(Give k	ent's Usual Occup	during most of	working	16b. Kind	d of Business/Ir	ndustry
7	within 72 ene. then "nat	ompleted	Elementary/Secondary (0-12)	College (1-4or 5+)	1	life. De	O NOT use retire	1)	v			
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yland	should be ind Mental I marked o	To Be	JOHN LOGA					HENRIETI			,	
ar <	shou and M amar	۲	19a. Informant's Name/Relationship (19t	o. Mailing	Address (Street		Rural Route Numb	KENN er, City or 7		p Code)
, Mar	and 2		JACQUELINE M. CARRERA	/DAUGHTER					RE, MARYLANI			
9.0	ges 1 and 2 should b of Health and Ment: If Item 27 Is marked or other treumatic e		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place o	of Disposi	tion (Name of story or other place	ce)	Date	20c. Loca	ation - City or T	own, State
Ĕ	Pag ment ent: I		`4 □ Donation 5 □ Other (Specify		FORT L	INCOL	N CREMATOR	Y 09/	/26/2005	BRENTW	OOD, MAR	YLAND
Baltimore,	permit. Pages 1 Department of H Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Licer	Rudouna	,	HINE	Name and Addre	FUNERAL	HOME, INC.	7D CDD1	INC MADV	7 AND 2000/
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	/Medical		resulting in death)	Due to (or as a		of):						
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ρ	ificate g phy as the	Medical		. 0								
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J.	requires that the een signed by th hould be detache	۵.	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the unc	lerlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
g	quires n sign ald be	d by							10	Yes 2□1	No 3 ☐ Pro	bably 4 ∑Unknown
cord	law red as bee 2 shou	ompleted							24a. Was	an :	24b. Were auto	opsy findings available
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VITa	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	۵۵.		3C DOA Oth		Death Check only o			
O	□ ~ co	\vdash	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	28b.	Time of	28c. Injur	y at	g Home 5 🖾 Resident			(y)
<u></u>	nding ath. r: Afte e fun	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(ear)	Injury	M 1 🗆	k? Yes 2 ∐ No				
DIVISION	lor Atten after deat Director:	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, fa (Specify)	arm, stree	et, factory, office		28f. Location (S City or Tox	Street and fr vn. State)	Vumber or Run	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 X Certifying Ph (Check only one)	ysician: To the best of endinger: On the basis of endinger: and manner state	xamination ar	e, death o	occurred at the fir stigation, in my o	ne, date and pla pinion, death o	ace, and due to the occurred at the time,	cause(s) an date and pl	nd manner as s ace, and due t	stated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
	4		1 Claredon	of reaus,	wens.	_	D3979	3	0	гртгмо.	ED oo o	205
	7		30. Name and address of person who	(1					5	PL TEMPI	ER 22, 20	000
			CHRISTOPHER J. MAYS, M			ILIP I	DRIVE, OLN	EY, MARYL	AND 20832			
	Sta		31. Date filed (Month, Day, Year)	7. Registrar's	s Signature	boar	Les Contractions					

			State of Maryland / Department Certifica	nt of Health and N te of Death		2005	33009
			1. Decedent's Name (First, Middle, Last)	ic or beatin	2. Date of Death	g. No.	3. Time of Death
	Physici /Medio		Vivian Gibson Poindexter		Month Sept	Day Year 7 2005	7:27PM M
	Examir	er		, Town, or Location of Death		4c. County of Death	t
				Hagerstown	B. Date of Birth	Washingtor	<u>_</u>
	Funeral Director		1 □ M 2 □ F	Days Hours Min.	8. Date of Birth (Month, Day,	Year) Coui	//
Н	- 10		407-03-7666 25 84 115. Usual Residence of Decedent		Nov 10	1920 Kent	ucky
	/land		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	Man	ţ	Maryland Washington Hager	stown			1 □Yes X No
	h the	irec		p Code	10	g. Citizen of What Cour	ntry?
	th wit	by Funeral Director	19026 Longmeadow Rd	21742		U.S.A.	
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, sp	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
9	or Ite	교	1 Never Married 2 Married 1 Yes 2 No		nican, etc.)	Black, White,	nite
ဗ္ဗ	rel',	d b	3 XWidowed 4 □ Divorced Year or Dates:	ZIANO Specily.		Specify: WI	
<u>.</u>	n 72 h	Completed	15. Decedent's Education 16a. Decedent's Usi (Specify only highest grade completed) (Give kind of w	ial Occupation ork done during most of work use retired)	ing 1	6b. Kind of Business/In	dustry
2	withir ane. Ithan	E	Elementary/Secondary (0-12) College (1-4or 5+)	maker		Persona]	l Residence
N	iled v Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)	18. Mother's Name	/First Middle M	nidon Sumama)	
ano	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or Items 23a or 28a-f show attic event, the Medical Examination in the training at	Be					
Maryland 21215-0036	hould Me mark	မ	Reese Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	s (Street and Number or Rura		ple Gibson	Code
<u>≅</u>	d 2 s Ith an 17 Is trau			ell Spring Dri			
ā,	1 an Heal tem 3		20a. Method of Disposition 20b. Place of Disposition (Na	me of		Oc. Location - City or To	
<u>o</u>	ages ant of t: If I		1 XBurial 2 □ Cremation 3 □ Removal from State 1 Donation 5 □ Other (Specify) **Cemetery, crematory or Rest Haven Cemetery, crematory or Rest Haven Cemetery or Rest Haven Cemete			Hagerstown	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Maryleal Examination until conditional angone.			- 1 A A A A A PT 10 A	_		
Ba	permi Depa tmpo any ir		No Maria	DC	-	Fiery Fund	
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State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ANTHONY PANETTIERE SALVATORE SR. September 8, 2005 9:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 639 Security Road Hagerstown Washington Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 192 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 153-16-8987 12€ M 2 ☐ F 83 Yrs Director New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f ehow the Medical Examinational be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21740 639 Security Road United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No 1942—
If Yes, Give
Year or Dates: 1945 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Menial Hygiene. important: If item 27 is marked other than "ns any injury or other traumatic event. It is Medic once. Elementary/Secondary (0-12) College (1-4or 5+) inspector truck manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Benjamin Panettiere Giovannia Tizio 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Security Road Dorothy Panettiere wife Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory 9-9-05 ' 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME tred 415 E. Wilson Blvd., Hagerstown, Md. L. Vsdil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 1 □ Yes 4 DUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 Yo Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Netural 5 Pending 1 ☐ Yes 2 ☐ No safter death 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1136 31. Date filed (Month, Day, Year)-32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 09

			1- State of Maryland / Department Certificate			ne 2005	33011
	Physici		Decedent's Name (First, Middle, Last) Syed Quadri		2. Date of Death	2 ^{Day} 20°05	3. Time of Death 6:05 p.M
	/Medio Examir			own, or Location of Death		4c. County of Death	
	Funeral Director		630-40-3318 AM 201 73 Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y)	9. Birth Cou 926 Indi	place (State or Foreign ntry) i A
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Montgomery Potomac Mar	yland			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	h with the 23s or 28s	ai Director	10e. Street and Number 10f. Zip C 208		i i	. Citizen of What Cou	ntry?
980	be filed within 72 hours after death with the Maryland hat Hygiene. id other than "natural", or Items 23a or 28a-f show event, the Medical Exeminant mast be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, specified by Year or Dates: 13. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, specified by Year or Dates:	ent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: AS	etc.
Maryland 21215-0036	i within 72 ho lene. r than "natur tha Medical.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 16a. Decedent's Usual (Give kind of work life. DO NOT use unemployed)	k done during most of workin e retired)	9	b. Kind of Business/In	dustry
land 2	buld be filed Mental Hygid arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Muzafuddin Quadri	18. Mother's Name Raaja		iden Sumame)	
, Mary	and 2 should be raith and Mental 127 ia marked er traumatic ev			(Street and Number or Rural nselman Rd.			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ta marked any injury or other traumatic enone.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Namcoemetery, crematory or oth Maryland Nat.	ional 9/24/	05 La	c. Location - City or To	ı.
Balt	permit. Departi Import any inj		1 1 Ker	Address of Facility UNinnedy St.,	N.W. Wa	shington	, n, DC20011
	Physician /Medical Examiner		23a. Part1. Enter the of sease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A. Metastatic Pancre Due to (or as a consequence of):				Approximate Interval Between Onset and Death
60,		I Examiner	Sequentially list conditions, france cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last b. Due to (or an a non-eequence of):				
.O. Box 68760,	death certifi e attending d for use as	Physician/Medical	d			23d. Date of delive	er y Day Year
σŽ	requires that the d een signed by the nould be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
Vital Records	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed	prior to con death?	psy findings available impletion of cause of
of	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 1 X Accident X Accident 28a. Date of Injury (Month, Day Year) M 4	the state of the s		e 6 ⊡Other (Specifi	v)
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Algorithm of the funeral by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		City or Town, S		
	the Hosp thin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	n my opinion, death occurred	d at the time, date	and place, and due to	the cause(s)
)	1343	_	Elle (111218		Date signed (Month,) / 24 / 2005	Day, rear)
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mil 31. Date filed (Month, Day, Year) 32/Registrar's Signature	ll Rd., Roc	kville,	Md. 208	5.5
	Registr	-	31. Date filed (Month, Day, Year) SEP 2 7 2005 32 Registrar's Signature				

		1 - State M. D., TCHD, Registrer 1. Decedent's Name (First, Middle,			tificate of I		2. Date of Dea			3. Time of Death	
Physicia /Medic		Walter (liver Ringgol	ld			Month Sept.	Day 24	Year 2005	1:34 A M	
xamin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	r Location of Death		4c. (County of Death		
		Caroline Hospi		lo at hinth days)	Dento		Date of Bird		Carolin		,
ral tor		5. Social Security Number 214-30-8113 Usual Residence of Decedent	6. Sex/ 1M M 2□ F 7. Age (In yrs	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day Jan. 28,	, Year) 1934		place (State or Foreign ntry) 1and	_
tabel	0	10a. State 10b. County		City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No	
Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Caroli 10e. Street and Number	ne l	Ridgely	10f. Zip Code			10g. Citiz	zen of What Cou	ntry?	-
	rai	22840 Peavine			21660			USA			
	/ Funerai	11. Marital Status 1 □ Never Married 2 Marrie	12. Was Decedent Ever in to Armed Forces? 1 ☐ Yes 2ऒ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White Specify:		
al E.S.	ed by	3 Widowed 4 Divorced 15. Decedent':			.,				B1a		_
MENIN	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work d)	ing	16b. Kin	nd of Business/Ir	idustry	
	Соп	10		Truc	k Driver				nean Gra	in	_
	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name					
	To	unk 19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailin	ng Address (Street	Eleanor and Number or Aura		nsor		n Code)	_
er trac	(1)	Reba Ringgold				Road, Ri					
	H	20a. Method of Disposition 1		Place of Dispo	sition (Name of matory or other place	1 1	Date		cation - City or T		
land		'4 ☐Donation 5 ☐ Other (Sp	ecity)		Grove Cem		-2005	Dent	on,Mary	land	
any in		21. Signature of Funeral Service L	icensee	22	Rame and Address. Bennie S	Smith Fune	eral Hom	ne			
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the dea	ath. Do not ent	er the mode of dyin	er Street, ng, such as cardiac	Easton or respiratory an	, Mar rest,	yland 2	Approximate Interval Between	
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	ai Examiner	Sequentially list conditions, if any, leading to immediate case. Each the carrying Cause (Disease or injury that initiated events resulting in death) Last									
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State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** RILEY 25 ARLETHA SEPTEMBER 2005 6:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛣 F 69 APRIL 29 1936 Director 578-48-7734 WASHINGTON, DC Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Mudical Exercines must be notified at 1 Xes 2 No WASHINGTON, DC Director DC: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 U.S.A. 3457 EADS STREET N.E. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours etter of Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item any injury or other treumatic avent. Its Mudical Exertinat ODGS. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 X Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th CLERK **GOVERNMENT** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FELTON WILLIAMS MARY GILCREST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL RILEY/SON 5707 37th AVENUE HYATTSVILLE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Surial 2 □ Cremation 3 Removal from State HARMONY CEMETERY 10/1/05 LANDOVER, MARYLAND 5 ☐ Other (Specify) 21. Signature of Furieur Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trensit and Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical signed by the attending physical be detached for use es the 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 215 2 0 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy performed? Yes 2 1 ☐ Yes 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Sepatient examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Alter t Natural 5 Pending death. 1 □ Yes 2 □ No 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 5 45050 0 10 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 6 2 2 1 LL O Ke 2001 ach 2 Talcu 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 2 7 2005 Registrar

			For State Registrar	State of	Marylan	d / Depa		Health and Death	Mental Hy	_	- pun	33014
			1. Decedent's Name (First, Middle, I	ast)					2. Date of Dea		V	3. Time of Death
	Physici /Medi		STEVEN	F		RC	WE		Septem	cher 13	7ear 2005	2209 M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	ber)		4b. City, Town, o	or Location of Deat	h	4c. County	of Death	
			Sina: Hospital	of 13a	Him			more			L'IMORI	
	Funeral Director		5. Social Security Number 6. 221-30-2599 Usual Residence of Decedent	Sex 7. 1 ▼ M 2 □ F	. Age (In yrs. 57		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	h y, Year) 3, 1947		ace (State or Foreign ry) ON, DE
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Illed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or Items 23a or 28e-f ehow int, I're Medical Examinational Lean-uillied at	ţō	MD CECI	Г.		ELKTON						1 ☐ Yes 2X No
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Asr.	2 sh and Is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Ru	ural Route Numbe	r, City or Town,	State, Zip (Code)
S	1 and Health em 27		KATHRYN D. ROWE	E / WIFE	20h P	31 B	UTTON BUS	SH COURT.	ELKTON,	MD 219	21	- 01-1
Š	~ ~ ~ .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		ate DEL	AWARE	VETERANS	ce) I	0/2005		•	n, State
Raltimore	it. Pa rtmer rtent njury		*4 □ Donation 5 □ Other (Special Service 10)			ORTAL.	CEMETERY	03/2			R, DE	
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Cur	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Caro	ch line. LO UU r as a consequ		lar F	ailury	e			nterval Between Onset and Death
092	e be executed rician and e burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r as a consequ							
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Division	or Atteno after death Director: in by the	Certification:	3 Suicide 6 Could not determine	286. Place of	f Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory, office		.28f. Location (S City or Tow	treet and Number, State)	er or Rural I	Route Number,
_	To the Hospital or within 24 hours afte to the Funeral Discompletely filled in	edical Ce	(Check only 2 Medical Ex	Physician: To the baseminer: On the base	is of examinal	wledge, deat	n occurred at the tir	me, date and place	a, and due to the durred at the time	ause(s) and ma	nner as stat	ted.
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	10+14	11	30. Name and address of person wh	14	of death (Item	23a) (Type,		ileval 1.	1.) . 110	0.00	10 20
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Rec	istrar's Signa	6 / / / ture	park	Heights	rive, 13	altim	JIE/1	(NI) 212/5
	Regist		SEP 2 6 200	Beach	. #	Sport						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** ARAH JANE STANT 13:05P LPTEMBER 262005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTONN NURSING 3 REMAIS CEN HESTERTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JULY25, 1 1923 Birthplace (State or Foreign MD Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 82 1 □ M 2 □X 213-14-7973 Yrs. Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shows at the position of the po MD KENT CHESTERTOWN 1 XYes 2 No Director the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 301 CAMPUS AVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after dea nent of Health and Mental Hygiene.
ant: If Itam 27 Is marked other than "natural", or Itams ury or other traumatic avent, the Madical Experiment. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY DEPT OF CORRECTIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN CLAYTON CHAMBERS DELLA PLUMMER RICHARDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $P.O.\ BOX\ 92\ MASSEY,\ MD\ 21650$ MARGARET NEWMAN/SISTER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. injury or CHESTERFIELD CEMETERY SEPT 30,2005 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Hame and Address of Eachily ENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses rik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO PULLIONING ARREST Pnysician /Medical **Examiner** Cerebro Vescular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit ResTeusin Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the as use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Severe Pempheral Vonculan 1 res 2 No 3 Probably 4 Unknown Seven Renpheral 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2□ No of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ₹No Certification: To uneral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor: / 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 123889 9127/06 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) 10)3 M. D. 223 High Street, CHES LES FORDER, Wed 2/620 Volum C. ATERAISAL VK. 31. Date filed (Month, Day, Year) State SEP 2 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #5 Per FH G850 12/19/05 JH State of Maryland Department of Health and Mental Hygiene State Registrar WCHD/SH 10/4/05 per DR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2, 2005 **Physician** Steven, Kenneth 3
4a. Facility Name (If not institution, give street and number, 1055 September /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital 1.Ta1 Hagerstown
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 5 1986 **Funeral №** M 2□ F Months Days 19 Yrs. Director Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location or 28a-1 show e notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Ravenswood Drive 21740 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Exeminer filed within 72 hours after Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. s 1 and 2 should be filed w f Health and Mental Hygier Itam 27 Ie marked other t Student College traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Steven Kenneth Spalding 2 Jill M. Charles Spalding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Kenneth Spalding (father) buy Raveliswood 20a. Method of Disposition (Name of cemetery, crematory or other place) 609 Ravenswood Drive Hagerstown Maryland 21740
of Disposition (Name of 20c. Location - City or Town, State Baltimore. other tam ō **= 6** 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Rest Haven Cemetery 4 Donation 5 Other (Specify) 9-28-05 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 un Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Severe 18 pour chosed /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe Bilateral hemophermothoraces 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 🗌 Pending MYC 09/21/05 ~ 6 PM 1 Yes 2 No investigation 2 Accident ofter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

L-West between Exit 32 & L-5/ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 170000 filled in by 4 Homicide Hagerstown, mp 24 hours e Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0050337 20105 9/22/2005 amb 30. Name and address of person who completed cause of death (Item 23a) (Type, Punt) Marc E Kross 351 & Antietam Hagerstown, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State SEP 29 2005 Registrar

		ricase	State of Ma				•	-	•
		1_ For State	State of Ma				Mental Hygid	2005	33017
		Registrar 1. Decedent's Name (First, Middle, La.	-41		Pertificate of	Death	2. Date of Death	LNG, UUU	
Physic	cian						Month	Day Yea	
/Med	lical	Xavier Lamonte			4h Cihi Taua		September	24 200	
Exam	iner	4a. Facility Name (If not institution, give		1/ 1:	40. City, 10Wn,	or Location of Deat	(a) 1	4c. County of De	atn
		5. Social Security Number 6. 8	PICEINIS 7. Age	(In yr last birtho	(av) If Under 1 Year	FIMOR C	8 Date of Wirth	Q R	irtholece (State or Foreign
Funera Directo			∑ M 2□F	Yrs	Months Day	s Hours Min.	(Month, Day, Y		irthplace (State or Foreign Country)
		Usual Residence of Decedent			2!	2	Aug 30	2005	aryland
rylan how	_	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
e Ma	cto	Maryland Washin	gton	Hager	stown				1 ☐ Yes 2X No
or 2:	Funeral Director	10e. Street and Number			10f. Zip Code	1	100	p. Citizen of What (Country?
ath w	ā	17229 W. Washin				21740		United S	
ar de Items	une	11. Marital Status	12. Was Decedent E Armed Forces?		 Was Decedent of If Yes, specify Cu 	f Hispanic Origin? (S ıba <mark>n, Mexica</mark> n, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 X N If Yes, Give Year or Dates:	0	1 □ Yes 2√∑ N	o Specify:		Specify: B	i-Racial
hou sture	ed	15. Decedent's Ed		16a. Di	ecedent's Usual Occ	unation	16	b. Kind of Busines	
nin 72	piet	(Specify only highest gra	ide completed)	(C	live kind of work don e. DO NOT use retii	e during most of wo	rking	D. KING OF BUSINGS	Sindustry
filed within Hygiene.	Completed	Elementary/Secondary (0-12) N/A	College (1-4or 5-	+}	N/A			N,	/A
III. Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel" or items 23a or 28a-f show event, I'm Modical Exercit et hard be notified at	O O	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Ma		
	To B	Airy Lamont Sum	mers Sr			Sarah	Tymotto	MaElroy	
intiliote, Mal yid nit. Pages 1 and 2 should artment of Health and Men ortant: If item 27 Is marke injury or other traumatic	ľ	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Stree	et and Number or Ru	I Lynette . ural Route Number, (City or Town, tate,	Zip Code)
1 and 2 Health em 27 I		Sarah Lynette M	cElroy (Mo	ther) 1	7229 W. Wa	shington	St. Hager	stown Mar	yland 21740
of He roth		20a. Method of Disposition 1 Temperature 2 Cremation 3 C	Domoval from State	20b. Place of Di	sposition (Name of crematory or other p			c. Location - City of	
parmit. Pages Department of Important: If it eny injury or o		'4 □Donation 5 □ Other (Specify	y)	Rose H	ill Cemete	erv Sent	- 27 05	Hammetov	m Maryland
Dattillity permit. Pag Department Important: I eny injury o	ė	21. Signature of Euneral Service Licer	ISBB /		00 11				
0 &85 5 8	3	1 Ward	Talley		1331 Eas	stern Blvc	N. Hage	rstown Ma	neral Home Eryland 21742
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each lin	the death. Do not	enter the mode of dy	ying, such as cardiad	c or respiratory arrest	l,	Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition		ry Insuffic					Onset and Death
/Medica		resulting in death)		consequence of):					0/30/05 1/21/05
Examine		Sequentially list conditions.	t. Prematu						3/3905-9124/0S
ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):	Lizerez, co				dala daylor
ecut and I-tran	хап	that initiated events resulting in death) Last		n houl consequence of):	Hem sina	_			93005-91244
ate be executed hysician and he burial-transit	calE		a. Hypote						dedo= alvulos
oor ficate g phys			d. 1141010	nston.					player 115 (12)
certii nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	_			23d. Date of d	aliveny
d for	cial	in the past 12 menths?	1⊡Live birth 2 4⊡Pregnant at t		3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	Day Year
the och the ache	hys	9 Unknown	9□ Unknown						
s thai	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlying cause g	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
w requires (been signer should be							1 🗆 Yes	250 No 3□F	Probably 4 Unknown
awre s bee	Completed						24a. Was an	24b. Were a	utopsy findings available
The I	Eo						autopsy performe	death?	
Cien:	O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ☐ ath (Check only one)	1 L Ye	3 27110
ysic ysic jis ca dirac	To B	examiner?	Hospital: Inpatier	nt 2 ER/Outpa	tient 3 DOA	ther	lome 5 Residence	e 6 Other (Sp	ecify)
ng Phy ter this		27. Manner of Death	28a. Date of Injun (Month, Day	Year) 28b. Tim Inju	e of 28c. Inj		28d. Describe how		
aath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation	1			∃Yes 2 □No			
r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, (Specify)	street, factory, office	9	28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
rel Di									
Hosp 4 hou Fune ely fil	ical	Check only and Medical Exam	ysicien: To the best of the basis of	examination and/o	eath occurred at the rinvestigation, in my	time, date and place opinion, death occu	, and due to the caus	e(s) and manner a	s stated. e to the cause(s)
To the Hospital or Atlanding Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.		nse number			
To To Io		Signature and title of certifier Bu	March					Date signed (Mon	
		1				PS-000	Se	plember 2	4,2005
H-1		Janine E. Bull	completed cause of de	ath (Item 23a) (Ty	pe, Print)) . Pallana	o MN a	207	
	tate	31. Date filed (Month, Day, Year)	32. Redistra	r's Signature	Souls	- ; parrino	1e, MD 21:	481	
Regis		31. Date filed (Month, Day, Year)	2005	J.	Sperker				

Baltimore, Maryland 21215-0036

Robert Smith

Phys /Me Exar

Funer Direct

	1-	For State Registrar		State of Mary	nand / D	Certific	ate of L	Death	id Me		Reg. No		0.5	330	18
ician		ecedent's Name	e (First, Middle, La	st)					2	2. Date of Dea Month	ath Da	ay	Year	3. Time of C)eath
dical			PIERRE S							Sept	23		005	3:35	_AM
ninér				e street and number) Care - The	Dino			Location of Caston	Death		40		of Death		
		ocial Security N			yrs. last birtl		Londer 1 Year	If Under 24	Hrs. 8	B. Date of Birth	h	1.0			Foreign
al or	5	78 30 6	790	MYM 2DE	•	rs. Mont	ths Days		Min.	(Month, Day EB. 18	v, Year,			place (State or intry) HINGTON	
	10a.	. State	10b. County	10	c. City, Town	or Location								10d. Inside City	Limits
to	MA	RYLAND	TALBOT		EASTON									XXYes 2	2 □ No
ire	10e.	. Street and Nur	nber				Zip Code				10g. Ci	itizen of \	What Cou	intry?	
Funeraj Director	3	KENSING	TON DRIV	E			21613				UNI	TED	STAT	'ES	
nue	11. /	Marital Status		12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Do	ecedent of Hi specify Cuba	ispanic Origin n, Mexican, P	? (Spec Puerto Ri	ify Yes or No- can, etc.)			e - Ameri ck, White	ican Indian, , etc.	
2	1 3	Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	1 ☐ Yes 2☐XNo If Yes, Give Year or Dates:		1 🗆 Ye	s XXNo	Specify:				Specify	v: WH	ITE	
Completed		(Spec	15. Decedent's E- ify only highest gra		16a.	Decedent's U	Jsual Occupa work done o	ation during most of)	f working	,	16b. K	Kind of B	usiness/Ir	ndustry	
a	- EI	lementary/Seco		College (1-4or 5+))		-					
ပိ		12TH Father's Name ((First, Middle, Last)		UNI	KNOWN	18 Mother's	Name /	First, Middle,				OF INTE	RIOR
00		BERT B.								COMPHE			,		
2			ame/Relationship (Type, Print)	19b.	Mailing Add				Route Number		or Town.	State, Zi	p Code)	
	1		LOWERY /	FRIEND	1/4	-	GTON D			ON. MD				,	
	20a.	. Method of Disp	position	2	Ob. Place of	Disposition (Da	77.1			City or T	own, State	
			☐ Cremation 3 ☐ 5 ☐ Other (Specil	Removal from State	CEDAR	-	-	1	/28/	2005	c	IIT TT	AND.	MD	
9			Peral Service Lice		CLDAR										
once	1	1.7	· Illan			4308	HALL'S SUITL	AND RO	AL E	OME OF	MA AND	KYLA MD	ND, I 207	NC. 46	
	23a	a. Party Enter the	he disease, or com	plications that caused the one cause on each line.	death. Do no									Approximate Interval Between	een
10	Imn	mediate Cause ((Final	Aso	instito	nn	neum	min						Onset and De	ath
al		ulting in death)	(a Due to (or as a co	onsequence o		percino	,,,,,						days	
er -	Son	quentially list cor	nditions	b. Tysp	hagia) ⁽⁸⁾								Beers	e 11
ne.	if an	quentially list cor ny, leading to im ise. Enter Unde use (Disease or	mediate ertying	Due to 🦱 as a co				1. 1						1	
an L	that	use (Disease or t initiated events ulting in death) l		c. ores	VOVES!	war	acce	am						years	
Ē		J.,,,,		Due to (o, as a co	ensequence of class	ni Este Tambi		est.						years	
edical Examiner				d.	J CALLY	125		7~ .					-	Jeans	
		EMALE:		23c. If yes, outcome of p	regnancy							03d Da	to of dollar		
Completed by Physician/M	23b	 Was decedent in the past 12 	months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐Ectopi 5 ☐ Other	c pregnancy						te of deliv inth	ery Day Ye	na.r
VS		1 Yes 2 5		9☐ Unknown			(0,000)								
9	Part	II. Other signif	icant conditions	contributing to death but n	ot resulting in	the underlyir	ng cause give	en in Part I.		23e. Did to	bacco	use cont	ribute to t	the cause of dea	ath?
D D		love	mary a	Teny diseas	e				_	1 🗆 Y	es 2	□No	3 ☐ Pro	babiy 4 Min	known
jete		1.00	terrice 6	andin muson	rethy					24a. Was a		24b. 1	Were auto	opsy findings av	ailable
E										autops perfor	sy njed? 23. No		prior to co death? 1 □ Yes	mpletion of cau	ise of
a di	25	Was case refer	red to medical					26. Place of	Death (Check only or		,	103	20 140	
To B		examiner? 1 Tes 2	No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3	DOA Othe	or: Nursi	ng Home	5 Resid	ence	6 Oth	er (Speci	fy)	
	27.	Manner of Deatl	h 5 🗌 Pending	28a. Date of Injury (Month, Day Ye	28b. Ti	me of jury	28c. Injury Work	at		d. Describe h					
atic		2 Accident	investigatio	n		М		res 2□No							
Į		3 Suicide 4 Homicide	6 Could not b determined		At home, far Specify)	m, street, fac	ctory, office		28	f. Location (S City or Town	treet ar n, State	nd Numb e)	er or Run	al Route Numbe	er,
S			/												
Medical Certification:	29a	a. Certifier (Check only one)	Certifying Ph 2 Medical Exar	nysician: To the best of m niner: On the basis of exa and manner stated	amination and	death occur or investigat	red at the tim tion, in my op	e, date and pointion, death o	olace, an occurred	d due to the c at the time, d	ause(s late an) and ma d place,	and due t	stated. to the cause(s)	
Ň	296	. Signature and	title of certifier	200	25		29c. License	number	20-27	2	29d. Da	-		Day, Year)	
				Millow	/			VZ59	22			9:2	73.0	5	
/	30.	Name and addr	ess of person who	completed cause of att	(Item 23a) ((ype, Print)	1	1	٠	T.	,	nn	^	0:=0	7
	\mathbb{L}_{μ}	NCHAEL	- ROW	MEY, MB	610 I)UTCH	MANS	MANI	<u> </u>	LAST	ON	, 11	Ŋ	216	
State	31.	Date filed (Mon		33. Registrar's	Signature	/					-				
strar -		SE	P 2 8 200	Elever.	St. A	rack	,								

		For State Registrar		State of	of Maryla	nd / Depa <i>Ce</i>	artment of H	lealth and N Death		giene Reg. No.	005	33019
Physic /Medi		1. Decedent's Name	ne (First, Middle, La	,	7e Greg	ory Son	de		2. Date of De Month Septem	Day	4, 2005	3. Time of Death 5 12:50 A.M
Examir			If not institution, given		mber)		4b. City, Town, or Davidso	Location of Death			ounty of Death	
Funeral Director		5. Social Security N	Number 6. S		7. Age (In yrs	. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec . 1	th	9. Birth	nplace (State or Foreign
yland Now		Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	ecation					10d. Inside City Limits
he Mar 28a-f st	Director	Md.	Anne Aru	indel			avidsonvi	lle		10- 01		1 ☐ Yes 2 No
th with t	al Dir	10e. Street and Nur 2000 G	resham La	ne			10f. Zip Code	21035		US.	in of What Cou A	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event. If we dired Example, until be rediffed at once.	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ried 2 <mark>X</mark> Married 4 □ Divorced	12. Was Dec Armed Fo 1 1 Yes If Yes, Gi Year or D	2 □ No ve	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	1	Race · Amer Black, White pecify: Whi	, etc.
within 72 ho lene. r then "natur the W. digal	Completed	(Spec	15. Decedent's Eccify only highest gra		1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Presider	during most of work)	king		of Business/li ercial	ndustry Construction
be filed tal Hygi d other event.	Be	17. Father's Name	(First, Middle, Last)			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	respices	18. Mother's Nam		_		Onstruction
should nd Men marke imatic	^L	19a. Informant's N	ame/Relationship (Martin Type, Print)	Sonde	19b. Maili	ng Address (Street a		e Green		Town, State, Zi	ip Code)
and 2 ealth a m 27 is		Victori		- Wife		2000	Gresham	Lane, Da	vidsonv	ille,	Md. 21	1035
mit. Pages 1 bartment of H cortant: If ite Injury or otl		`4 □Donation	□ Cremation 3 □ 5 □ Other (Specification Licer	(y)	State	cemetery, crea	sition (Name of natory or other place S Cemete 2. Name and Addres	e) ry 109–26	5-05 eall Fur	Long		own, State New York
Deg		>	00/18-	10)	eall		6512 N.W.	Crain Hv	vy., Bov	vie, N	C 200	
Physician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	on	a. Pan	caused the dea each line. Creation (or as a conse	Cance		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 14 months
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
phys the	dical	d										
The law requires that the death certific ste has been signed by the attending p page 2 should be detached tor use as	Physician/M										d. Date of deliv Month	very Day Year
w requires that the de been signed by the should be detached	by	Part II. Other signif	ficant conditions of	contributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to			the cause of death?
	Completed		***						24a. Was autop perfo 1 \(\text{Yes} \)		24b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of 2 No
Physician: The this certificate ral director, pag	o Be	25. Was case referexaminer?		Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DOA Othe	26. Place of Deat			Other (Speci	(6.1)
ending Phy eath or: After this he faneral o	-	27. Manner of Deat 1 XNatural 2 ☐ Accident	th 5 Pending investigation	28a. Date (Mon		28b. Time o	28c. Injury Work	at	28d. Describe I			··y)
To the Hospital or Attending within 24 hours after death To the Furieral Director: After completely filled in by the funer	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
the Hosp the Fure the Fure	Medical	29a. Certifier (Check only one)	2 ☐ Medicel Exam	niner: On the b	asis of examin	ation and/or in	occurred at the tim vestigation, in my op	pinion, death occurr	red at the time,	date and pl	ace, and due t	to the cause(s)
S T Wild		29b. Signature and	mi B	amn	~)	140	RE!	7 ~ 00C		Sept	24 th	2005
4		30. Name and addr	ress of person who	ERJ 7	se of death (Ite	m 23a) (Type,	kins Hos	pital, 4	OL NB+	oudw	ay, Bal	Day, Year) 2005 Limore, MD
Sta Regist	rar		P 2 7 200	5 Ke	wes A	1. Spo	The same					

DHMH 17 Rev 1/2001

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1	For	epartment of Health and N Certificate of Death	lental Hygiene	33020
	Physicia	an .	- Registrar AMEND#SperFH9/27/05, BMW, McCo 1. Decedent's Name (First, Middle, Last) 'Thelma Saunders		2. Date of Death	3. Time of Death
	/Medic Examin		la. Facility Name (<i>If not institution, give</i> street <i>and number</i>) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton	4c. County o	of Death
- -	Funeral Director	2	5. Social Security Number 6. Sex 1 M 2 反 F 7. Age (In yrs. last birt. 1. A	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)1931 05/31/ 05	9. Birthplace (State or Foreign Country) N • C •
	Maryland -f show		10a. State 10b. County 10c. City, Town	or Location n Hill		10d. Inside City Limits 1 ŽYes 2 No
	h with the 3a or 28a st be notil	<u>a</u>	10e. Street and Number 1443 Southern Ave	10f. Zip Code 20745	10g. Citizen of W	· ·
036	72 hours after death with the Maryland natural, or items 23e or 28e-f show disal Examinal must be notified at	by Fur	11. Marital Status 1 Never Married 2 Married Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race Black Specify:	- American Indian, k, White, etc. Black
121	within	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Nurse Aid		y Hospital
TO	be filed ttal Hyg d other event,	To Be Co	17. Father's Name (First, Middle, Last) Wallace Clingman	Iola	e (First, Middle, Maiden Sumame Herbert	
d)	l and 2 tealth a im 27 io		Shawn Rogers Daughter 3 20a. Method of Disposition 20b. Place of cameter	Mailing Address (Street and Number or Run 506 Parkway Ter.D Disposition (Name of y. crematory or other place) ington National 9	PR Suitland, Mo	1/1
Baltir	permit. Pages Depertment of Himportant: If its eny injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sr. 5732 Georgia Av	ead Funeral I	
	Cate be executed hysician and physician and physician and the buriar transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the	iage renal du tension		Approximate Interval Between Onset and Death
Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date Mon	e of delivery hth Day Year
rds, P.O.	w requires that t been signed by should be detai	क्	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		ibute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,		Completed			autopsy performed? d 1 Yes 2 No 1	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 22100
Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ★ npatient 2 ☐ ER/Ou	Other	th <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐ Othe	er (Specify)
ision of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Fime of njury at Work? M 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number	
Div	pital or A ours after here! Directilled in by		4 Homicide determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge		City or Town, State)	
	he Hos in 24 h the Fur ipletely	Medical	(Check only one) 2 Medical Examinar: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occu	rred at the time, date and place, a	and due to the cause(s)
	T ME S	×	29b. Signature and title of certifier Rahima au MD	29c. License number D00 5 2 9 0	1	(Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a)	7501 CHARATTE	ROAD 205 C	UNTON MD 20735
	St Regist	ate rar	31. Date filed (Month, Day Year) SEP 2 7 2005 32. Registrar's Signature	Agentis		

			_ For	State of M	arylar	nd / Depa	artment	of He	ealth a	and M	ental Hyg	giene o	o. ==	00001
			1 - State Registrar			Cei	rtificate	of D	Death				U5	33021
Г	Physici	an	Decedent's Name (First, Middle, La ETHEL	st)	SACK	c					Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number			4b. City, To	own, or I	ocation of		SEPTEM	BER 23,		3:50A M
	Exami	ei	15310 PINE ORCHA			3F			SPRI				GOME	RV
Ī	Funeral		5. Social Security Number 6. 5		ge (In yrs.	last birthday)	If Under 1		If Under 2 Hours	-737	8. Date of Birtl (Month, Day	1		lace (State or Foreign
k	Director		578-32-0663 Usual Residence of Decedent	I N ZW	85	Yrs.						, 1920		YORK
	yland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Ba-f s	ctor	MARYLAND MONTGO	MERY		SILVE	R SPRI	NG						1 XYes 2 No
	with the	by Funeral Director	10e. Street and Number	D DD T112-			10f. Zip C					10g. Citizen of V	Vhat Cour	itry?
	ns 23	eral	15310 PINE ORCHAR	D DRIVE, A				0906		nin? (Sne	cify Yes or No-	U.S.	A. e - Americ	an Indian
ဖွ	after or iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣)					, Puerto F	cify Yes or No- Rican, etc.)	Blac	k, White,	
5-0036	within 72 hours after death with the Maryland one. then "neturel", or items 23a or 28a-f show the Medical Evaring must be notified at		3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2X		Specify:			Specify	· W	HITE
215	in 72 n "net	Completed	15. Decedent's E (Specify only highest gra	ade completed)		16a. Deced (Give	dent's Usual kind of work DO NOT use	Occupat done du retired)	ion <i>iring m</i> ost	of workin	g	16b. Kind of Bu	ısiness/Ind	dustry
212	d with giene. er the	omi	Elementary/Secondary (0-12)	College (1-4or	5+)		ACHER	,				EDUC	ATIO	N
nd	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden Suman	ie)	
Maryland	should be ind Mental s marked o umetic eve	P		LLER		T				FAN			TENS	
	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (MICHAEL SACKS -	* * * * * * * * * * * * * * * * * * * *								BIA, MD		
Jre,	es 1 and of Health fitem 27		20a. Method of Disposition	-	20b. F	Place of Dispo cemetery, cren	sition (Name	of				20c. Location -		
Ĕ	Pages ment of ent: if its ury or o		1 X Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specil			EAN ME	-			9/25	/2005	OLNEY,	MARYI	LAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumetic event, it a Medical Evaninar must be notified at once.		21. Signature of Auneral Service Licer	1500			Name and							
	20200		23a. Paryl. Enter the disease, or com	plications that cause	the deat	h Do not ent	170°RU	CKV)	ITEE	PIKE	ROCK	L CHAPE	b ^S 208	Approximate
	Physician		Immediate Cause (Final	one cause on each i	ne.	RVOUS :					respiratory arr	631,		Interval Between Onset and Death
il e	/Medical		disease or condition resulting in death)	a. Due to (or as			OI OI EM	LIF.	IF ITOPI	A			ľ	IONTHS
	Examiner	_	Sequentially list conditions,	b										
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):								
o,	execu an and rial-tra		that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):								
8760	death certificate be executed e attending physician and ind for use as the burial-transit	dical	(d										
Ó	eath certifici attending pl	/Mec	IF FEMALE:	23c. If yes, outcome	of pregns	IDOV.								
Box	death a atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic preg Other (spec					23d. Date Mor	e of delive oth	ry Day Year
л О	res that the de signed by the a be detached	hys	9 Unknown	9□ Unknown										
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Ö	w require been si should b	eted									-		3 Proba	ably 4 □Unknown
Vital Records,	The lav	Completed									24a. Was a autops perforr	у р	Vere autop rior to com eath?	sy findings available opletion of cause of
<u>ta</u>		O	25. Was case referred to medical						26 Place o	of Death	1 Yes 2	Λ	☐ Yes	2 No
0	Physicien: r this certifica ral director, p	ToB	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpatie	ent 2	ER/Outpatien	3 DOA	Other:				ence 6 Othe	r (Specify,)
טעכ	ing After une	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		. Injury a Work?			3d. Describe ho	w injury occurre	ed	
DIVISION	eatt or:	ertification:	2 Accident Investigation 3 Suicide 6 Could not b		ury - At ho	ome, farm, stre	M eet factory o		s 2 N		If. Location (St	reet and Numbe	or Rural	Route Number
S	s after s after sl Dire	Certi	4 Homicide determined	building, et	c. (Specify	γ)	,,,				City or Town	, State)	. 0. 110.4	rioute rumber,
	Hospi 4 hour Funer ely fill	edical (Z Intodical Exal	ysician: To the best	of my kno f examina	wiedge, death	occurred at	the time,	, date and	place, an	d due to the ca	ause(s) and mar	ner as sta	ited.
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifier	and manner sta	ated.			icense r		-		9d. Date signed		
			I Chihè ly	12)424.						
	10		30. Name and address of person who				Print)					SEPTEMBE		
			CHITRA RAJAGOPAL, 31. Date filed (Month, Day, Year)					DRI	VE, S	SUITE	327, 0	LNEY, M	D 20	832
	Sta Registr		SEP 2 7 20	Registr	ai s signa	iture	te)							

Replacement

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Rag. No. 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 20, 2005 **Physician** SADACCA ELEANORE 7:38P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 □ ▼F 75 102-24-4891 Director JULY 25, 1930 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28e-1 show traumetic event, the Mudical Examiner must be notified at MARYLAND PRINCE GEORGES ADELPHI 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 1836 METZEROTT ROAD, 20783 APT. 1806 UNITED STATES OF AMERICA Items 23e death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
is marked other than "natural", or Itel 1 Never Married 2 Married ☐Yes 2☐No Yes, Give X WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Wivorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MORRIS LEVENBERG FANNIE ERDAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health an Important: If item 27 is any injury or other trat QDCE. AMY E. SADACCA - DAUGHTER 10012 LOVE SONG COURT, LAUREL, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 09/25/05 OLNEY, MARYLAND 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. neral Service Licensee EDWARD SAGEC FOUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death Immediate Cause (Final Priysician CARDIAC RUPTURE MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MYOCARDIAL INFARCTION DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💹 No Month Year į Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral I 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fun completely t (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D36601 OCTOBER 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7901 MAPLE AVENUE, TAKOMA PARK, MD 20912 DAVID BRILL, MD32. Registrar's Signature State

Registrar

2005

			For S = State Registrar	tate of Maryland		artment of He		, 0	iene .g. No 2005	33023
	Physicia	an	Decedent's Name (First, Middle, Last)	thas				2. Date of Death		3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street 14718 Myer Terrace			4b. City, Town, or Rocky	Location of i11e	Sept.	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Birth (Month, Day, Dec. 15,	Year) 9. Bi	rthplace (State or Foreign country)
	ryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	h the Ma r 28a-f s r cuiffe	Director	Maryland Montgomer 10e. Street and Number	y Ro	ockvil	1e 10f. Zip Code		10	ng. Citizen of What C	1 X Yes 2 ☐ No country?
	23a c	raiD	14718 Myer Terrace				853		USA	
36	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene. And the than "natural", or Items 23a or 28a-f show event. Its Medical Examerat must be notified at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? If Yes 2 ₹ No If Yes, Give ↑ Year or Dates:	ĺ		spanic Orig n, Mexican, Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
2-0	72 hou nature	eted	15. Decedent's Education (Specify only highest grade co	on mpleted)	(Give	lent's Usual Occupa kind of work done di	uring most	of working	16b. Kind of Busines	s/Industry
21215-0036	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than "itraumatic event, the Mer	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ome Maker			Own Hom	e
Maryland	uld be fil Aental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) Haralambos Sakis					's Name <i>(First, Middl</i> e, <i>N</i> 'odite Anton		
Mary	12 short	1	19a. Informant's Name/Relationship (Type,	Print)				or Rural Route Number, Rockville,		Zip Code)
ē,	t Health		Constantine Spithas 20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	1	Date 2	20c. Location - City o	r Town, State
Baltimore,	artment o ortant: If injury or		1-1 Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	of H	eaven Cem	•		ilver Spri	•
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	20/4	22	. Name and Address	s of Facility 2222 Wash	DeVol Funer Wisconsin Lington, D.C	Ave 20007.W	•
	Physician /Medical		23a Fafii. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ause on each line.	ion				est,	Approximate Interval Between Onset and Death 2 Year
b	Examiner	_	Sequentially list conditions, b.	Hunytus	ence of):	acular	Disc	an		5 years
o,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	liros	J				8 years
68760	icate be physicia s the bu	edical	d							
.O. Box (law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnancy Other (specify)	٠		23d. Date of de Month	elivery Day Year
<u>α</u>	quires that the signed by all the detaction	by	Part II. Dther significant conditions contrib	uting to death but not resu	Iting in the ur	nderlying cause give	n in Part I.	23e. Did tob		to the cause of death?
Vital Records,	0 5 0	Completed	Ostevar Hivit Domentia					24a. Was ar autopsy perform 1 Ves 2	prior to death?	utopsy findings available completion of cause of
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital		0#-		of Death (Check only one		
of	Phys this al dii	ation: To	1 Yes 2 No Hosp 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	ER/Outpatien 28b. Time of Injury	t 3 DOA Othe 28c. Injury Work M 1 Y	at ?	28d. Describe ho		ecify)son's home
Division	or Attency after death Director:	Certification:	3 Suicide 6 Could not be determined	8e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	tural Route Number,
	Hospita 4 hours Funeral ely fille	edical C	29a. Certifier Certifying Physicia (Check only one) Certifying Physicia Certifying Physica Certifying Physica Certifying Physica Certifying Ph	n: To the best of my know On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and inion, death	place, and due to the can occurred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the I within 2.	Me	29b. Signature and title of pertifier	X3 e MAT)	29c. License	number 468	<u>(</u>	Od. Date signed (Mon	th, Day, Year) 22, 2005
•	1		30. Name and address of person who comp Robert F. Dyer, M.D.			· ·	Chor	y Chase, MD		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2005	32 Registrar's Signat			onev	y onase, rm	20013	

		ŀ	1 - For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of Hea	Ith and ath		giene ()	05	33024
13/2	A		1. Decedent's Name (First, Midd	le, Last)						2. Date of De	D	Year	3. Time of Death
	Physici /Medic		Sang		Shin					Septer	nber 2	23 2005	0330 AM
	Examin		4a. Facility Name (If not institution	n, give street and r			4b. City, To	own, or Loca	ation of Dear	h	4c. Cou	inty of Death	
~3			Soint Agurs	Healtho	AVT.		Bal	tima	VC			•	
78	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If L	Jnder 24 Hrs		th V Year)	9. Birth	place (State or Foreign
	Director		219 72 0727	1 X M 2□ F	77	Yrs.	WOITINS	Days	Julis	July 2	,		rea
	P.	-	Usual Residence of Decedent										
	urylar thow	_	10a. State 10b. Count	/	10c. Cr	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	cto		ward	E1	kridge							
	er 2	Director	10e. Street and Number				10f. Zip C	Code			10g. Citizen	of What Cou	ntry?
	23a		7104 Elk Mar Di				_	21075				Korea	
	or de	Funerai	11. Marital Status	Armed	ecedent Ever in U Forces?	J.S. 13.	Was Deceder	nt of Hispar y Cuban, M	nic Origin? (S exican, Puer	Specify Yes or No to Rican, etc.)		Race - Ameri Bfack, White,	
36	or t	by F	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	IT YOS,	s 2 kNo Give		1□Yes ₹	No Sp	pecify:		Spe	ecify: 🗛 🕳	ian
21215-0036	s within 72 hours after death with the Maryland Jiene. I than "natural", or Iteme 23a or 28a-f show The Medical Examinar must be notified at	d b			Dates:	10+ P	danda tita da	0			401 161 1		
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	illed Il Hygie other		8 17. Father's Name (First, Middle	Lasti			Owner		Mother's Na	me (First, Middle	Sewing	g Work	Shop
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Maryland	d Me d Me nark natic	T ₀	Hak Soo Shin 19a. Informant's Name/Relation	ship (Tuna Print)		10h Mailir	an Address (Street and I		Lee ural Route Numb	or City or To	um Stato 7i	n Cadal
Ma	h an 7 ts r		Bok Soon Shin	3-3111									
	1 and 1 ealt 1 m 2		20a. Method of Disposition	MILE	20h 8	Place of Dispo			ive Ei	kridge,		ana on - City or T	21075
Ö	To F To F		1 Burial 2 Cremation		m State	cemetery, crer	natory or oth	er place)	1				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic engine.		4 □Donation 5 □ Other		/ Ft	Linco	In Cre	mator	y 9/2	7/2005	Brent	twood,	Maryland
Sal	Departiment of the poor of the		21. Signature of Funeral S. rvice	Licensee	1_					es Rinal			
	00 5 8 0		etual.	Cleu	sou.							Sprin	g, MD 20904
25			23a. Part1. Enter the disease, of shock or heart failure. Lis	r complications that t only one cause of	it caused the deal n each line.	th. Do not ent	er the mode	of dying, su	ich as cardia	c or respiratory a	rrest,		Approximate fnterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. A-1	ha/05	0/0/7	Fir (ard	INVE	Stula	DIT	ecte	Jakaswa
	/Medical		resulting in death)	Due	to (or as a consec								V .)
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	nd nd trans	Examiner	that initiated events	C									
oʻ	e exe	Ĕ	resulting in death) Last	Due t	to (or as a consec	quence of):							
8760,	cate be executed physician and i the burial-transit	dical		d									
9	ng ph	1 00 1	fF FEMALE:										
Вох	death certifi e attending I id for use as	an/	23b. Was decedent pregnant		outcome of pregna e birth 2 Peta		Ectopic pred	anancv			23d.	Date of deliv	,
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S, F	The law requires that the tite has been signed by the bage 2 should be detache	by F	Part II. Other significant condit	ions contributing to	death but not res	sufting in the u	nderlying cau	use given in	Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
ij	w require been sign									1 🗆	Yes 2□N	o 3 🗆 Pro	bably 4 Unknown
ပ္ပ	s be	olet								24a. Was		tb. Were aut	opsy findings available
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tal		C	25. Was case referred to medic	al				26	Place of De	1 ☐ Yes ath (Check only o	20 No	1 🗌 Yes	2L NO
5	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 20 No	Hospital:	Inpatient	ER/Outpatier	nt 3 DOA	Othor		dan (<i>ones</i> only t		Other (Speci	6.0
O		!-	27. Manner of Death	28a. Da	te of Injury	28b. Time of		c. Injury at		28d. Describe			(97)
o	ding f th: After funer	ţ	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ng (Mi	onth, Day Year)	Injury	м	Work? 1 ☐ Yes	2 🗌 No				
Division	Atter dea octor	flee	3 ☐ Suicide 6 ☐ Could	nined 286. Pla	ice of Injury - At h	ome, farm, str	eet, factory,	office		28f. Location (Street and Nu	umber or Rur	al Route Number,
Ö	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide	bu	ilding, etc. (Speci	fy)				City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier Certify	ng Physician: To	the best of my kno	owledge, deatl	h occurred at	t the time, d	ate and plac	a, and due to the	cause(s) and	manner as	stated.
	e Ho 24 r e Fui letely	edical	(Check only 2 Medica one)	I Exeminer: On the	basis of examina anner stated.	ation and/or in	vestigation, it	n my opinio	n, death occ	urred at the time,	date and pla	ce, and due t	o the cause(s)
	To the within 2 To the complet	₹	29b. Signature and title of certific	ər			29c.	License nur	mber		29d. Date sig	gned (Month,	Day, Year)
)	->-0			than 1	01"	5 P- 2	1	717	> < 2		Conta	3	23 2mm5
•	6		30. Name and address of person	17/27411	9 Thys	14197	Print)	3/0			>1-1-71-	w. 50/	00,2003
	~		MI - Des A	Si /VEV	,	900	Cat	200 1	2102	R-	14	r. I D	23,2005
	Sta	to	31. Date filed (Month, Day, Yea.		. Registrar's Sign	ature /	el a	va t	IVER	C 36	17100	or t	0,00
190	Registi		SFP 2 6	2005	Dura D	GOO							

		•	1- State of Maryland / Depa Registrar Cert	rtment of Health and I tificate of Death		2005	33025
	Physicia		1. Decedent's Name (First, Middle, Last) Franklin Donald STOTELMYER Sr.		2. Date of Death	Day Year 2005	3. Time of Death A
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washingt	ion
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Young 11,1	ear) Cour	place (State or Foreign ntry) 11and
	anyland show	2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc Market Lond		· · · · · · · · · · · · · · · · · · ·	1	10d. Inside City Limits 1 ★ Yes 2 No
	with the M a or 28a-f	Director	Maryland Washington 10e. Street and Number 13711 Emily Street	Hagerstown 10f. Zip Code 21742	10g	. Citizen of What Cour	
ဖွ	d within 72 hours after death with the Maryland jiene. Ir them "neturelt, or Items 23e or 28e-f show Itre Madical Examiliar must be invitted at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12 Married 1 □ Never Married 1 □ Never Married	/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert ☐ Yes 2♥ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	etc.
Maryland 21215-0036	n 72 hours "neturel",	leted by	15. Decedent's Education 16a. Deceder (Give k	ent's Usual Occupation find of work done during most of wor O NOT use retired)	rking 16i	b. Kind of Business/In	vhite dustry
d 212	TO TO THE	e Completed	Elementary/Secondary (0-12) College (1-4or 5+)	metal worker	ne (First, Middle, Mai	sheet meta	ı1
ylan	Menta Menta arked	To Be	Lewis Victor Stotelmyer			rine Rohre	
	and 2 sho alth and 27 is mu er traum			Address (Street and Number or Ru Emily St., Hage:			
altimore,	Pages 1 and 2 nent of Health int: If item 27 I		1 M Buriai 2 Cremation 3 Hemoval from State	ition (Name of atory or other place) Cemetery 9/10		c.Location - City or To	
Balti	permit. Pages Department of the Importent: If ite eny injury or of once.		cott MM/unner 41	5 E. Wilson Blvd	., Hagers		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Du Lo (or as a consequence of): Sequentially list conditions, if any, leading to immediate	r the mode of dying, such as cardiac FOM ZOLINS	c or respiratory arrest		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examine	if any, leading to immediate cause. Enter Undertying Cause (Enter Undertying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	,			
.O. Box 6	the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	quires tha n signed uld be det	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to the	he cause of death?
Records,	The law requires that ate has been signed b page 2 should be deta	Completed	More sid Ober the		24a. Was an autopsy performed	d? prior to condeath?	ppsy findings available impletion of cause of
on of Vital	ng Physicien: Iter this certific neral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	ath (Check only one)	ce 6 □Other (Specify	
Division	tel or Attending s after death. el Director: After ed in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State)	tl Route Number,
	Hospil 4 hour Funer ely fill	edical C					
) z	1 V	Σ	29b. Signature and title of cartifier	29c. License number)86 ^{29d.}	Date signed (Month)	Day, Year)
	4+104		30. Name and address of person who completed cause of death (Item 23a) Type, F	821 0a/4	hill ow	P) Ha	208500
	Sta Registi		SEP 0 9 2005 22 pegistrar's Signafure	ile		1/12/	pirt -

Jaxtome /on perme

State Registrar

Schiffler, Elizabeth

31. Date filed (Month, Day, Year) 2005

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FANMO

KRISTILE

1209 COASTA HIGHWAY. 32. egistrar's Signature

Amend item#22, perDVR, G848, 10/11/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year obert Smith 10:00PM September 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. 2/17/1920 Berlin Rehabilitation Morsing and arity Number 18. Sex Worcest 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F 219-07-6944 85 Maryland Yrs Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-f ahow other treumatic event, the Medical Examinar must be rollined at Director Worcester 1 Yes 2 □ No Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8355 Newark Road 21841 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No If Yes, Give Year or Dates: 1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 73 in and Mental Hygiene.
7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Liquor Control Board 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Smith, Robert Wilmer L. Smith Ella Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other treum once. P.O. Box 57, Newark, MD Dortha Hess, Caregiver 21841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Qurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Garden 9/29/2005 Newark, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee The Burbage Funeral Home 23a. Part1. Enterithe disease, or complications that caused the death. shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease) 108 William St., Berlin, MD 21811 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntestinal obstr **Physician** month 031CL /Medical Due to (or as a consequence of): Examiner abdon, intra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Hinnown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an onary autopsy performed? sea 2 100 1 Yes 2 40 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DQA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospitel or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number OE 29d. Date signed (Month, Day, Year) C1-0006795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a.H. 12+1 KRISINE 6 1209 MO COASTAL HIGHWAY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

legistrar's Signature

2005

			1 - For State Registrar	State of Maryla		artment of H		_	giene Reg. No 20	05 3	3028
la la	Physic		Decedent's Name (First, Middle, Last	rd SHAFER, Jr				2. Date of De		Year 3. Tir	me of Death
	/Medi Examir		4a. Facility Name (If not institution, give Clearview Nursing			4b. City, Town, or Hager			4c. County		10 p. ^M
	Funeral Director		5. Social Security Number 219-36-2599 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Birt Min. (Month, Da May 20,	y, Year)	9. Birthplace (St Country) Maryla	
	the Maryland 28a-f ehow	Director	10a. State 10b. County Maryland Washing 10e. Street and Number		ity, Town or Lo Willian				10g. Citizen of W	10	de City Limits]Yes 2X]No
36	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ha Medical Examinat must be notified at	Funeral	9431 Downsville	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1	21		in? (Specify Yes or No- Puerto Rican, etc.)	14. Race	USA - American India k, White, etc.	ın,
Maryland 21215-0036	be filed within 72 hours aft ntal Hygiene. nd other then "natural", or i event, the Medical Exami	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11	Year or Dates: cation e completed) Cotlege (1-4or 5+)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired,	ution	of working	16b. Kind of Bus	siness/Industry	
iryland (d 2 should be filed th and Mental Hygi 7 is marked other treumatic event.	To Be C	17. Father's Name (First, Middle, Last) Charles Edward 19a. Informant's Name/Relationship (Ty		19b. Mailin	o Address (Street a	Etl	's Name (First, Middle, hel Staley or Rural Route Numbe	Maiden Sumame	9)	
Baltimore, Ma	1 and 2 Health a Pm 27 is		Barbara J. Nutwe1. 20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) F 4 \(\times \) Donation 5 \(\times \) Other (Specify)	1 - daughter	3362 Place of Disposementary, crem		on tl	he Bay Rd.,	Annapo		te 4761
Balti	permit. Pages Department of Important: if it any injury or o		21. Signature of Funeral Service License	Ministr	415	Name and Address	s of Facility	MINNICH F	UNERAL I	НОМЕ	
	/Medical Examiner	Examiner	234. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	ncular quence of): value (1) quence of): Hell	vacuide svinary		7,5		Approxi Interval Onset a	imate I Between and Death
O. Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1	Ideath 3 🗆	Ectopic pregnancy Other (specify)	207-12		23d. Date Mont	of delivery	Year
ords, P.O.	w requires that the bean signed by should be detac	2	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause giver	n in Part I.			oute to the cause	of death?
	an: The law ratificete has be tor, page 2 sh	e Completed	25. Was case referred to medical				26 Place o	24a. Was a autops perform 1 Tyes 2	ned? de 2000 10	ere autopsy findin for to completion o ath? Yes 2 \(\text{No}	ngs available of cause of
Jivision of	or Attending P ifter death. Director: After t in by the funera	Certification; To B	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specifi	ER/Outpatient 28b. Time of Injury ome, farm, strey)	3 DOA Other 28c. Injury a Work? M 1 7 Ye	4 Unurs	ing Home 5 Reside	ence 6 □Other ow injury occurred	d	√umber,
	To the Hospital within 24 hours a To the Funeral I completely filled	ledicai	29a. Certifier (Chack only one) 29 Medical Examin 29b. Signature and title of certifier	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my opin	o, date and p nion, death	place, and due to the ca occurred at the time, da	ause(s) and mannate and place, and	ter as stated. d due to the caus	se(s)
			30. Name and address of the son who con	inpleted cause of death (Item	23a) (Type, P	DO C	627	223	9/13/0	S .	7 A 2
1H -	Star Registra	9	31. Date filed (Month, Day, Year) SEP 1 4 200	or: On the basis of examinal and manner stated. In pleted cause of death (Item PLA VEC	ture Soe	LALVM,	,340	11111 St.,	Hagerst	EWE, ML	191740

State of Maryland / Department of Health and Mental Hygier $\bigcirc \bigcirc \bigcirc$ 33029 For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day r 24, **Physician** Robert William Turner 2005 September 10:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1800 Gayfields Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** M 2 F Director Yrs 217-44-7286 60 July 31, 1945 North Carolina Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if liem 27 is marked other than "natural, or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event, the Medical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland Silver Spring Director Montgomery 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Gayfields Drive 20906 Funerai USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 γ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Russell Turner Helen Grant Mathez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Elise Turner/ Daughter 1800 Gayfields Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. Metropolitan Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Juneral Service Licenses Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma 6 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, ian/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year Physici 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Type II Diabetes Mellitus, Coronary Artery Atherosclero is 1 Yes 2 No 99 Completed 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? cate 1 🗌 Yes Division of Vital 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: A 6 Could not be determined 3 T Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) do D54853 September 26, 2005 30. Name and address of person who come sted cause of death (Item 23a) (Type, Print) 8317 Cherry Lane, Laurel, MD 20707 Danny Lee, M.D. 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item I per doc 2848 10-11-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2005 Certificate of Death Elizabeth Agnes Taylor 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** *ФСТОВЕК* 2005 5:19 A. TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth (Month, Day, Year) 2/14/1930 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Months 1 ☐ M 2**X**☐ F Yrs. 75 Director 212-28-8758 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Jarrettsville Director MD. Harford 28a-1 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ò 21084 United States 3974 Old Federal Hill Road Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces2 1 Tes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Massey Connors Jerome ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Ia n any injury or other traum William H. Taylor/Husband 3974 Old Federal Hill Rd. Jarrettsville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Carroll Cremation 10/6/05 Hampstead, Maryland 14 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic see Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician curer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Justice of the initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ρ in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes □ No 24a. Was an autopsy performed? 1 Yes V2□ No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ihis Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho
To the Func (Check only one) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 0002361 032250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar DR. DAVID DUNN

31. Date filed (Month, Day, Year)

BEL AIR, MD.

615 W. MACPHAIL ROAD

32. Registrar's Signature

		For State Registrar	State of Ma	aryland		rtment o				giene Reg. No 200	5 33031
		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	3. Time of Death
Physicia /Medic		Demetrios Efstra		tolas					Septemb	per 23 20	05 11:39 P ^M
Examin	er	4a. Facility Name (If not institution, give s	treet and number)			4b. City, Tow Silver				4c. County of Montgo	
Funeral		Holy Cross Hospit: 5. Social Security Number 6. Sex	7. Age	e (In yrs. las	st birthday)	If Under 1 Ye	ear If Und	er 24 Hrs.	8. Date of Birt (Month, Da		Birthplace (State or Foreign
Director-		215-36-4246	M 2□F	92	Yrs.	Months Da	ys Hour	s Min.	Sept 17	, Year) 1913	Greece
pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	oation					10d. Inside City Limits
laryla •hov	'n										1 ☐ Yes 2 ☑ No
the N 28e-i	Director	MD Montgomer		SIIV	er Sp	10f. Zip Cod	de			10g. Citizen of Wha	it Country?
h with	io ie	900 McCeney Avenue	2			2	0901			United St	tates
deat	Funeral	11. Marital Status	2. Was Decedent ! Armed Forces?		. 13. \	Vas Decedent Yes, specify (of Hispanic	Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
S after	by Fu	1 Never Married 2 Married	1 ☐ Yes 22☐21 If Yes, Give			I□Yes 2🏋			, , , , , ,	Specify:	
21215-UU36 within 72 hours after death with the Maryland liene. rthen "natural", or items 23a or 28e-f ehow the Madical Examiner intertor intertor	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a Decec	lent's Usual Oc	cunation			16b. Kind of Busin	
PP - " W	Completed	(Specify only highest grade	completed)		(Give	kind of work do DO NOT use re	ne durina m	ost of work	ring	TOD. KING OF DUSIN	ess/modstry
IG Z1Z1	mo;	Elementary/Secondary (0-12)	College (1-4or 5)**/	Real 1	Estate	Invest	tor		Real Est	tate
and d be file antal Hy ced otha	Be	17. Father's Name (First, Middle, Last)	1							Maiden Sumame)	
YIA	2	Efstratios Tsinto					-		[sakares		
Ore, Marylanc es 1 and 2 should be fi of Health and Mental I ff item 27 is marked ot r other treumatic ever		19a. Informant's Name/Relationship (Ty)	9/1							r, City or Town, Sta	fe, Zip Code)
Heal Heal tem 2		Fotini Economides 20a. Method of Disposition	/ Daugnt	20b. Pla	ce of Dispo	SITEATWO sition (Name of natory or other	f		Date	MD 20816 20c. Location - Cit	y or Town, State
Pages nent of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State					Sept 2	28 2005	Brentwood	l, MD
Baltimore, permit. Pages 1 ar Department of Hea Important: If them eny injury or othe		21. Signature Funery Service License	2,)	1						ler's Son	
n 88 5 8 8		Macm 6	MY .		5.	l30 Wis	consi	ı Ave.	. NW Was	hington,	DC 20016
k .		23a. Part1. Inter the disease, or compli- shock or heart failure. List only on	cations that caused e cause on each lir	the death. ne.	Do not ent	er the mode of	dying, such	as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Acute	Myoca	rdial	Infarc	tion				Criser and Death
/Medical Examiner		resulting in death)	Due to (or as								
** ** *** **	ē	Sacuentially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	ry Art	tery I)isease					
uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events									
8 / 60, ate be executed hysicien and the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseque	nce of):						
8 / 6U, sate be executed bhysicien and the burial-transit	dical										
Geeth certific		IF FEMALE:	3c. If yes, outcome	of pregnance	ev.					224 Date of	L deliane
BOX leeth cer attendin i for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3	Ectopic pregna Other (specify				23d. Date of Month	Day Year
5	hysi	9 Unknown	9□ Unknown								
* # B #	by P	Part II. Other significant conditions con	tributing to death bi	ut not result	ing in the ur	nderlying cause	given in Pa	rt I.			te to the cause of death?
require									1 🗆 Y	′es 2 ⁴ ⊡No 3[Probably 4 Unknown
S S S S	Completed								24a. Was autop	sy prio	e autopsy findings available to completion of cause of
al MG									perfo	med? deal 2⊠No 1□	n? Yes 2□ No
VITAI sician: T certificet irector, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	ospitaf: 1 ☐ Inpatie	- X-	R/Outpatien	25 004	Othor		h (Check only o		0
g Phys g Phys er this eral di	—	27. Manner of Death	28a. Date of Injur	ry 2	8b. Time of	28c. I	njury at	Nursing Ho		ence 6 Other (Specify)
VISION (Attending I death. ctor: After y the funer	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day	y rear)	In j ury		Work? 1∐Yes 2	□No			
DIVISION I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory, off	ice		28f. Location (S City or Tow		r Rural Route Number.
pitel o		20. Costiline 1570 outifules Dhou	inian Tababas	-4 1 1							
DIVISION OF VITA Within 24 Hospitelen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 1 Certifying Physical Examination (Check only one)	ier: On the basis of and manner sta	examinatio	on and/or inv	estigation in a	by opinion	and place, leath occur	red at the time,	tause(s) and manne tate and place, and	or as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	-///	۹.	1	29c. Le	ense numbe	ər		29d. Date signed (A	fonth, Day, Year)
		> Heyell	·(M)	m	F	D20	6765			September	24, 2005
12		30. Name and address of person who co									
		Hector Collison MI	8401 Co.				/ Silv	er Sp	ring, M	D 20910	
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 20	05	ar s signatu	3	artas					

			For State	State of M	aryland / [Department of F		Mental H		OF	00000
			Registrar 1. Decedent's Name (First, Middle, I	act)		Certificate of	Death	2. Date of D	Reg. No.	00	3 3 0 3 2 3. Time of Death
	Physicia								mber 1	9. 200	5 1100 M
	/Medic Examin		LEMUEL A. THOMP 4a. Facility Name (If not institution, g		. — .	4b. City, Town, o	or Location of Death			nty of Death	
1	LXamin	CI.		ospital a		on Eas-	ton			albo	/
	Funeral		5. Social Security Number 6.		ge (In yrs. last bir	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	lirth Day, Year)	9. Birth	place (State or Foreignintry)
	Director		22026-3732	1 X M 2□F	82	Yrs.			, 1923	MD	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	Maryl f sho	ļo	MD QUEEN	ANNE I C	STEVEN	CVIIIF					1 ☐ Yes 2 📉 No
	r 28a	Director	10e. Street and Number	HINE 3	PIEAR	10f. Zip Code			10g. Citizen	of What Cou	untry?
	h with	a D	1235 LOVE POINT	ROAD		21666			USA		
	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jical Examinatination politied at	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or N	lo- 14. F	lace - Ameri	
36	or it	by Fu	1 Never Married 2 Married	1 ☐XYes 2 ☐ If Yes, Give	No 1943	1 ☐ Yes 2 No		, , , , , , , , , , , ,	Spe		WHITE
21215-0036	hours tural;	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1945	. Decedent's Usual Occup	-ation				
5	190	Completed	(Specify only highest	grade completed)		(Give kind of work done life. DO NOT use retire	during most of world)	king	16b. Kind of		·
212	filed within I Hygiene. other than rent, If a Max	mo	Elementary/Secondary (0-12) 6	College (1-4or		OAT BUILDER				RUCTI	ON
br	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, La	st)	···		18. Mother's Nam	ne (First, Middl	le, Maiden Surr	ame)	
Maryland	should be and Mental s marked o	To E	LEMUEL A. THOMP	SON, SR.			ANNIE I	. BAXTE	R		
lar	C ~ ~ ~		19a. Informant's Name/Relationship	(Type, Print)	195	b. Mailing Address (Street	and Number or Ru	ral Route Num	ber, City or Tov	vn, State, Zi	p Code)
	C - CI -		LEMUEL A. THOMP	SON, III/SO		108 COX NECE				619	
Baltimore,	L T of BS		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemete	f Disposition (Name of ry, crematory or other pla NWN MEMORIAL	ce)	Date	20c. Locatio	n - City or T	own, State
Itim	permit. Page Department Important: B any injury o		' 4 ☐ Donation 5 ☐ Other (Spe 21. Signal to of Lundral Service Lig		PARK		109/2	3/2005	EASTO	N, MD	
Ba	permit. I Departm Importal any injul		21. Signature du diferial del vice Eli	A CO	7/	FELLOWS, I	TELFENBEI	N & NEW	NAM FUN	ERAL	HOME, P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cruse	d the death. Do	106 SHAMRO				21619	Approximate
4	Dhysisian		Immediate Cause (Final	ly one cause on each I	ine.	a sta	1	,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	s a consequence	of Scower	L.				2 dez
4	Examiner		O constant of the second	0 1	monay	Edem	Q_				9 days
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence		. (/	2			0
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a cer			infarcl	w			9 days
60,	oe exician a	E	resulting in death) Last	· A	a consequente	ular direz	•				2.
68760,	tificate be executed ig physician and as the burial-transit	edical	•	d. COTON	1101010	are ares					2 unouel
-	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome	of pregnancy				224	Data of data	
Вох	death cert	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	у			Date of deliv Month	/ery Day Year
o.	that the de led by the a detached f	Physician/N	1 Yes 2 No 9 Unknown	9 Unknown							
S,	es tha igned I be det	by P	Part II. Dther significant conditions			n the underlying cause given	ven in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
ord	v require been sig should b	ed	a real	feeleve	2			1 🗆	Yes 2□No	3 🗌 Pro	babiy 4 Dnknown
Records,	e law re has be	Completed	anemie					24a. Wa	s an 24	b. Were auto	opsy findings available
	The ate ha	Con							formed?	death?	ompletion of cause of 2 No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea				
of	Phys this al dil	To	1 ☐ Yes 2 No	Hospital: 1 Inpati		Itpatient 3 DOA			sidence 6 🗆 0		fy)
	ding I h. After funer	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of 28c. Injury Wor	rk?	28d. Describe	how injury occ	urred	
Division	death death ctor: y the	licat	2 Accident investigat 3 Suicide 6 Could not	L =	iun, At home fo	M 1 □	Yes 2 □No	29f Location	(Stroot and Nu	mbor or Bus	nl Bouto Alumbau
Div	after Dire	Certification:	4 Homicide determine	building, e	tc. (Specify)	im, street, factory, office		City or To	own, State)	noer or Aur	al Route Number,
	spita nours neral		29a. Certifier Certifying	Physician: To the best	of my knowledge	e, death occurred at the ti	me, date and place.	and due to the	e cause(s) and	manner as s	stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	or examination an	d/or investigation, in my	ppinion, death occur	rred at the time	, date and plac	e, and due t	o the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
)			SMOK	(s.	1.ALI)	Do	0046020	,	9/1	9/05	<u> </u>
			30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type Print)			-		
			SYED I. ALI, M.	D., 506 ID	LEWILD A	VENUE, EAST	ON, MD 2	1601			
	Sta Registr		SYED I. ALI, M. 31. Date filed (Month, DEF) 2	2 2005 ^{32. Regin}	r's Signature	K A.					
DI	IMH 17 Rev 1/20	-		-	Jeway J	- Marie					
Dr.	nev 1/20	JU 1									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Nellie Pearl Thomas September 14 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Director Sep. 12, 1938 255-78-8044 67 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treumatic event, the Madical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Oxon Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20745 1341 Southview Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Tes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married African Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Completed by 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Cook Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Williams, Sr. Rebbeca (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5025 Hanna Place, S.E. #2, Wash., DC 20019 Jerome Williams - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 9/23/2005 Clinton, MD ure of Funeral Service License 21. Sign 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** ACUTE MYOCARDIAL INFARCTIONS /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physicien are the burial-1 Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. DIABETES 1 ☐ Yes 2 ☐ No 3 Probably 4 ₩nknown Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 100 REWAL FAILURE CHRONIC 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Att completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide t 🕒 Conflying Physician: Tu the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D40324 SEPTEMBER 15, 2005 30. Name and Adress of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND JODRIE, MID. TERRY 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 2 6 2005 Registrar

			Plea		Print in Black f Maryland / De	epartment of H	lealth and I	•	giene _	
- The State of the	Physici		1. Decedent's Name (First, Midde Phyllis Marie			Certificate of	Death	2. Date of De Month	3)5 33034 Year 2005 4.32 A ^M
	/Medic Examin		4a. Facility Name (If not institution Reeder's Memor	cial Home		Boonsbo		1	4c. County Wash	
	Funeral Director		5. Social Security Number 219-20-0460 Usual Residence of Decedent	6. Sex 1 ☐ M 21/2 F	7. Age (In yrs. last birtho	Months Days		8. Date of Bir (Month, Da 12/22/	th ly, _{Year)} 1926	Birthplace (State or Foreign Country) MD
	e Maryland e-f show	ctor	10a. State 10b. Count	ington	10c. City, Town of Hagerst					10d. Inside City Limits 1 XYes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 115 N. Jonatha			10f. Zip Code 2174			10g. Citizen of US	What Country?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or itama 23a or 28a-1 show other traumatic evant, the Medical Evant and marked notified at	by	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☎Divorce	rried 1 ☐ Yes	2 X No	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🌠 No		pecify Yes or No o Rican, etc.)	Specif	ce - American Indian, ck, White, etc. y: White
21215-0036	e filed within 72 h al Hygiene. I other then "netu vent, the Medice.	Completed		nt's Education est grade completed) College ((C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire Packer	during most of wor	rking		usiness/Industry
Maryland 2	2 should be filed and Mental Hyg is marked othar raumatic evant,	To Be C	17. Father's Name (First, Middle George W. Kau		\\		18. Mother's Nan Haze1	ne (First, Middle Marie D		ne)
	and 2 sho lealth and ! m 27 is ma		19a. Informant's Name/Relation Kimberly A. Ha		hter 204	Mailing Address (Street 2 Reed Road		lle, MD	21758	
Baltimore,	permit. Pages 1 am Department of Heali Important: If Itam 2 any Injury or other once.		20a. Method of Disposition 1	Specify)	State cemetery,	isposition (Name of crematory or other pla awn Mem. Pa 22. Name and Addre	ark 09/1		Hagers	town, MD Tuneral Home
	Physician /Medical Examiner	Examiner	23a Part1. Enter the disease, on the control of the	a	Acta Stati (or as a consequence of) (or as a consequence of)	t enter the mode of dyi		or respiratory a		Approximate Interval Between Onset and Death One 4 eg 1/
). Box 68760,	certificate b iding physic ise as the b	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	(or as a consequence of) tcome of pregnancy pirth 2 Fetal death and at time of death	3 Ectopic pregnanc 5 Other (specify)	у			te of delivery onth Day Year
rds, P.O	w requires that the death been signed by the atter should be detached for u		9 □ Unknown Part II. Other significant condit	tions contributing to d	eath but not resulting in the	ne underlying cause given SCULA	ven in Part I. W 0150	23e. Did t		tribute to the cause of death?
al Reco	The law ate has b page 2 si	Completed						24a. Was autop perfo	osy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Division of Vital Records,	Attending Physician: Thir death. sector: After this certificate by the funeral director, pag	Certification: To Be	E LI Modidoni	Hospital: 1 28a. Date (Montigation	Inpatient 2 ER/Outp. of Injury th, Day Year) 28b. Tim	ne of 28c. Inju	ry at	lome 5 Resi		
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft		4 Homicide deter	mined 289. Place build	of Injury - At home, farming, etc. (Specify) be best of my knowledge, of	death occurred at the ti	me, date and place	City or To	vn, State)	per or Rural Route Number,
)	To the Ko within 24 i To tha Fu completely	Medical	(Check only 2 Medica one) 29b. Signature and title of certifit	il Examiner: On the b and man	asis of examination and/o	29c. Licens	opinion, death occu	rred at the time,	date and place,	and due to the cause(s) d (Month, Day Year) 2005
	Sta Registi		30. Name and address of person Dr. Zafar Mal 31. Date filed (Month, Day, Yea SEP	ik 20311	se of death (Item 23a) (Ty Lappans Ro teg strar's Signature	ad. Boonsb	oro, MD		<u> </u>	

		•	1 - For State Registrar	iato or marytario		ificate of	lealth and N Death		ag. No 200	33035
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	_	3. Time of Death
	Physici		Marlys L. Unkenhol	Z				Septemb		05 6:10 P M
)	/Medic Examin		4a. Facility Name (If not institution, give street		4	b. City, Town, o	r Location of Death		4c. County of De	
	LXaiiiii		Montgomery Hospice	- Cagoy Hous		Rockvil	116		Montgo	morre
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo 9. E	Birthplace (State or Foreign Country)
E.	Director		470-24-6384 ¹□M	² √ F 82	Yrs.	Months Days	Hours Min.	Feb. 6,	1923 _{No}	rth Dakota
	ס		Usual Residence of Decedent						•	
	ylan		10a. State 10b. County	10c. City	, Town or Loca	tion				10d. Inside City Limits
	Ma F-f	ioi	Maryland Montgomer	y Sil	ver Sp	ring				1 ☐ Yes 21 No
	r 28	ire	10e, Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	1 wil	Funeral Director	11125 Easecrest Dr	ive		20902			USA	
	deat	ner	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	S. 13. Wa	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No-	14. Race - Al Black, W	merican Indian,
9	filed within 72 hours after death with the Maryland Hygiona. the than "natural", or items 23a or 28a-f ehow int, the Medical Examinar must be nutified at		1 Never Married 2 Marned	1 ☐ Yes 2 ☐ XNo If Yes, Give		Yes 2 TNo		Y Houri, Oto.,	Specify:Wh	
21215-0036	raf.	t by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					Specify.1111	
ည	72 h	Completed	15. Decedent's Education (Specify only highest grade co	on empleted)	16a. Deceder (Give kir	nt's Usual Occup	pation during most of work d)	ing	16b. Kind of Busine	ss/Industry
2	ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)			d)			
2	filed wi Hygien other th	ő		4	Home	naker	r		Own H	ome
g	m - 0 =	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u>ya</u>	Mental Merked o	၉	Lewis Larson				Selma Ti	neodora	Nottestad	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Howeverters: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any highly goother traumatic evant, the Medical Examinar must be nutified at any once.		19a. Informant's Name/Relationship (Type, Willard L. Unkenho						r, City or Town, State Maryland	
2	and salth n 27		willard L. onkenno							
altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	Co	ace of Disposit emetery, crema	ion (Name of tory or other plac		Date	20c. Location - City	or Town, State
Ĕ	2 5 E 5 D		4 □ Donation 5 □ Other (Specify)	Arl	ington N	ational Ce	ometers:	2005	Arlingto	n. Virginia
a	mit.		21. Signature of Funeral Service Licensee	<u> </u>	22.1 Fr:	Name and Addre	ess of Facility	Funeral	Home Inc	.,
0	88 = 8	6.3	1 undrew 1	Cole	500	O Univer	sity Blvd	d, W, Si	lver Spri	ng, MD 20901
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a second shock of the complete shoc	ons that caused the death	. Do not enter	the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Pnysician	or a	Immediate Cause (Final	End-Stage C						Onset and Death
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68760,	ficate be executed physicien and is the burial-transit	dicai	Ca							1
89	fication of physics the		4							
č	eath certifi attending I for use as	Physician/M		If yes, outcome of pregnar					23d. Date of	delivery
Box	atte d for	Cia	in the nast 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		ctopic pregnancy Other (specify)	у		Month	Day Year
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٣	Physician: The law requires thet the death certif r this certificate has been signed by the attending ral director, page 2 should be delached for use an	y P	Part II. Other significant conditions contrib	uting to death but not resu	ılting in the und	ertying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
sp	uires sign	d by	Advanced Dementia,	Congestive H	leart Fa	ailure		1 □ Y	es 2 🗆 No 3 🗀	Probably 4 JUnknown
Ö	w requir been si should	Completed						24a. Was a	n 24h Were	autopsy findings available
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Division of	o the Hospital or Attending thin 24 hours after death. o the Funaral Director: Afte mpletely filled in by the fune	Medical Certificatio	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Cartifying Physicial Examinar:	building, etc. (Specify an: To the best of my know	wledge, death o	stigation, in my o	opinion, death occur	red at the time, d	late and place, and o	as stated. lue to the cause(s)
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	Physici		1. Decedent's Name (First, Middle, Las Leda) Franchi	ık	Va	ssallo		Mon	of Death	Day Year 23, 2005	3. Time of Death 1:20P M
	- /Medio Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	on	Death		4c. County of Dear	h
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 10. Security Number 10	X 7 ☐ M 2 ★ 7	Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mor	of Birth oth, Day, Y ember	ear) Co	hplace (State or Foreign buntry) orth Pakota
	Maryland B-f show	tor	10a. State 10b. County Maryland Prince Geo	orge's	10c. C	ity, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2/1 No
	th with the 23s or 28 ast be not	al Director	10e. Street and Number 13120 Gallahan Road				10f. Zip Code 20	735		10g	. Citizen of What Co USA	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28s-1 show or other traumatic event, the Medical Exaction	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 ☐ Yes XI If Yes, Give Year or Date:	s? ∏ nNo		Was Decedent of H f Yes, specify Cuba I ☐ Yes 201 No	lispanic Origi an, Mexican, Specify:	in? (Specify Yes Puerto Rican, e	or No- tc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	vithin 72 hounder. han "nature. han "nature. han "nature.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most	of working	16	b. Kind of Business/	
and 2	be filed v ntal Hygie sd other t	Be	12 17. Father's Name (First, Middle, Last)			Sect	etary		's Name (First, I		Federal Gor iden Sumame)	vernment
Maryla	12 should be h and Mental 7 Is marked o rraumatic eve	10	Jack Franchuk 19a. Informant's Name/Relationship (7) Marilyn V. Woodruff / 1				ng Address <i>(Street</i> Gallahan R	and Number		Number, C	City or Town, State, 2	Cip Code)
altimore, I	iges 1 and 2 nt of Health : If item 27 or other tra		20a. Method of Disposition 1 🖫 Burial 2 🗀 Cremation 3 🗀	Removal from Sta	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20	c. Location - City or	
Baltin	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 2006.		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licenses)		was	22	Cemetery . Name and Addre 5160 Oxon H	ss of Facility	/28/2005 1 George 1 1 Oxon Hi		tland, Mary as Funeral I ryland 20	
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P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√√No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	Ectopic pregnancy Other (specify)	/			23d. Date of deli Month	very Day Year
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Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 🗍 Inpa	atient 2	ER/Outpatien	t 3 DOA Oth	05	of Death (Check		e 6 □Other (Spec	ifv)
Division of	Attending Phys or death. ector: After this by the funeral di	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Ir (Month, L	njury Day Year)	28b. Time of Injury	28c. Injur Wor	v at	28d. Des		injury occurred	,
Divis	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At h etc. <i>(Speci</i>	iome, farm, str	eet, factory, office			ition (Stree or Town, S	at and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Phy	rsicien: To the be iner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, death	place, and due occurred at the	to the caus time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To To T	M	29b. Signature and title of Shrifting	him	au		29c. Licens		2999	29d.	Date signed (Month	Day, Year)
2	(5)		30. Name and address of person who c	ompleted cause o		m 23a) (Type.	Print)		ROAL	205	CLIN	TON D 20735
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 7 2005	A. Regis	strar's Sign	ature_					*	

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death WCHD, C.H Reg. No. 2005 33037 Amended item #2,per Funeral Home, 10/07/05 2. Dete of Death Sept. 26, 2003 Time of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** ROBERT LEE WORTH, SR. Sept. 9, 2005 1:00 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 625 S. Camden Ave. Fruitland Wicomico 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Months Hours Director 220-01-8953 86 31, 1919 West Virginia Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Funeral Director MD Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 126 Eighth Street 21851 USA filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 AYes 3 Talional 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0020 If Yes, Give-Year or Detes: Guard 1 ☐ Yes 2X No Specify: Completed by Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Farmer Agriculture permit. Pages 1 and 2 should be filk Department of Haatth and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Herbert Lee Worth Blanche Barton 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert L. Worth, Jr. (son) 625 S. Camden Ave., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 10/2/2005 Pocomoke City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HOLLOWAY Melson Funeral Home, P.A. Run 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law raquiras thet tha death certificate be executed buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of geath? 4 Unknown 1 Yes 2 No 3 Probably þ this certificeta has been si rel director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending aftar daath. Director: Aft 1 Yes 2 No rector: , by the f 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide filled within 24 hours a To the Funeral D complataly filled 29a. Certifier 1 Cerutying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 100 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Many 3e) (Type, Print) C. H. 10+1 MD 145 Zest Carroll 10 egistrer's Signature State Registrar

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_			T = For State Registrar				Ce	rtificate	e of L	Death		Re	g. No.	000	33038
	Physici	an	Decedent's Name (First, Middle Jerry Alar		TTT							2. Date of Death Month Septembe:	Day	Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution					4b. City,	Town, or	Location of		ререспос.			2:50 P
1	3 *	iq į	11370 Days Cou					Waldo						Approximation of death? Date of delivery Month Day Date of George of the Countribute to the cause of the Countribute to the	
*	Funeral Director	0)	5. Social Security Number 227-41-9005	6. Sex 1 X M 2□	F	9 (In yrs. I 19	ast birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 03-09-19	986	Cour	olace (State or Foreign otry) 11, Korea
	land ow		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Lo	ocation						1	10d. Inside City Limits
	e Man	ctor	MD Char	les		Wal	dorf								1X Yes 2 □ No
	a or 2	Funeral Director	10e. Street and Number 11370 Days Cour	·+				10f. Zip	code 0603	2		10	g. Citizen o USA		ntry?
	me 23	neral	11. Marital Status	12. Was	Decedent E	ever in U.	S. 13.				gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Iteme 23a or 28e-f ehow enty injury or other traumatic event, the Medical Examinar must be notified at ance.		1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ned 1 🗆 Y	d Forces? ∕es 2√2 N s, Give or Dates:	lo		1 ☐ Yes 2		п, мөхісаг <i>Ѕресіту</i> :	1, Pu e rto	Hican, etc.)			
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Maryland	d 2 shoth and 7 is m		19a. Informant's Name/Relations Jerry A. Wills		ther)										
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x 68	ding ph	/Med	IF FEMALE:	23c If vas	, outcome	of pregna	nev								
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Δ.	s that t ned by e detac	y Ph	Part II. Other significant condition	ons contributing	to death bu	ut not resu	ılting in the u	nderlying ca	ause give	en in Part I.		23e. Did toba	icco use coi	ntribute to th	ne cause of death?
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	To the Hospitel or Attending Phwitin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifyir 2X Medical	Examiner: On the	o the best of he basis of manner star	of my know	wiedge, deat	h occurred a vestigation,	at the tim	e, date and pinion, deat	d place.	and due to the cau	se(s) and m	nanner as st	ated
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				SH	0/	V			C.M.	Е.		Se	ptemb	er 24	, 2005
اک	4-5		30. Name and address of person	GAN)		11		n St	reet.	Ba1	timore	Marv1	and '	21201
	Sta Registr		31. Date filed (Month, Day, Year)		12. Algistra	ir's Signat	y. A	rek	,			,	- w - y -	and t	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SEPTEMBER 24, 8:10P M 2005 ELLA MAE WILLIAMS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2XXF Yrs. Director 80 NOV. 28, 1924 KANSAS 509 20 0724 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Exeminer - dist be notified at XX Yes 2 No Director MARYLAND ANNE ARUNDEL GAMBRILLS 10e Street and Number 10g. Citizen of What Country? 10f. Zin Code 2610 CHAPEL LAKE DRIVE #209 21054 UNITED STATES Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes Ž\XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes XX No Specify Specify: BLACK à 3 ☐ Widowed XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than 12TH PROGRAM MANAGER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ie marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be ဨ MARY MAE BLANKS RAND E. KIRKPATRICK 19a Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNDA MARCELLI / DAUGHTER 2610 CHAPEL LAKE DR. #209 GAMBRILLS, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State RESSURECTION BAPTIST 10/01/2005 4 □ Donation 5 □ Other (Specify) CLINTON, MD 21. Signature of Funeral Strvice (icenses MARSHALL'S FUNERAL HOME OF MARYLAND, INC. iny is 4308 SUITLAND ROAD SUITLAND, MD 20746 ntir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate a se (Final disease or verilition resulting in death) Physician V 2 Ove /Medical Due to (or as a consequence of) Examiner de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us of consequence of): Examiner certificate be executed transit and Due to (or as a consequence of): burial physician a ician/Medical 25 attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Physi 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 25 1 🗆 Yes 2 🗌 No 1 Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 politient 2 1 Tyes 2 ER/Outpatient 3 DOA 28a. Dat of Injury (Month, Day 27. Manner of Death TUNatural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No · the Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide after 5 within 24 hours a To the Funeral completely filled 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Daje signed (Month, Day, Year) 29b. Signature and tip 29c. License number 2005 gause of death (Item 23a) (Type 30. Name and address of person

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 8 2005

Maryland 21215-0036

Baltimore,

Box 68760,

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82, Registrar's Signature

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/Med Exam		4a. Facility Name (If not institution, g 515 WILSON BRID	give street and number)	1	-	Town, or	Location of C		4c. Co	unty of Death	ORGES CO
Funera Directo		5. Social Security Number 579–54–9723 Usual Residence of Decedent		e (In yrs. last birthday 70 Yrs.	Months	Days	Hours I	Hrs. 8. Date of Br Min. (Month, D Augus	rth ay, _{Year} 19: t 22	9. Births Cour Wash	place (State or Foreign ntry) nington, DC
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Mary d 2 sho th and th and 7 is mu		19a. Informant's Name/Relationship Montrose H. Tyr						r Rural Route Numb			code)
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Train I	Certification;	3 🗓 Suicide 6 □ Could not 4 □ Homicide determine		6.1.1	treet, lactor			281. Location City or To	wn, State)	umber or Rura	al Route Number, son Bridge
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To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License				gned (Month,	
		30. Name and address of person wh	m ID	eath (Item 22-) (T.	Dei-1	0 0	МЕ		SEPTEM	BER 23	, 2005
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			State of State of Registrar	Maryland / Dep Ce	artment of He <i>rtificate of D</i>		ntal Hygien Reg. N		33041
	Physici	an	1. Decedent's Name (First, Middle, Last) Elizabeth C. Wright				Date of Death Month D Dember 23	ay 2005 Year	3. Time of Death 6:35 A. M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and num Southern Maryland Hospital	ber)	4b. City, Town, or L			c County of Death Prince Geor	1,
	Funeral Director			7. Age (In yrs. last birthday),		Hours Min. De	Date of Birth Month, Day, Year Cember 25,	9. Birthp Cour 1929 Wash	place (State or Foreign play) ington, D.C.
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	h with the	Funeral Director	10e. Street and Number 6505 Hill-Mar Drive Apt. #20)2	10f. Zip Code	20747	10g. C	U.S.A.	ntry?
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	should be filed nd Mental Hygis marked other matic event, II	To Be C	17. Father's Name (First, Middle, Last) Jack Covington		1	8. Mother's Name (Fi	rst Middle Maide ALice Ingr	an Sumame) am	
Maryland	nd 2 shi		19a. Informant's Name/Relationship (Type, Print) Francine S. THompson (Daughte		ing Address (Street an Hil-Mar Driv	nd Number or Rural Rove Apt. #202	oute Number, City Forestvill	or Town, State, Zip e, Marylan	1 20747
Baltimore,	Pages 1 au nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cometary, cre Chesapeake	matory or other place)	nc. Septemb		Location - City or To)5 Beltsvil	own, State 1e, Maryland
Balti	permit. Pages i Department of H Importent: If Ite any Injury or ot		21. Signature of Funeral Service Licensee		2. Name and Address 339 Hunt Plac				
	Physician /Medical Examiner	ner	23a. Part. Enter the disease, or complications that ca shock, or heart failure. List only one cause on earlier disease or condition resulting in death) Sequential y list conditions, if any, leading to immediate cause. Enter Underlying	in as a consequence of the conse					Approximate Interval Between Onset and Death
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1		ate	Kelso Scott A., M.D. Scothe 31. Date filed (Month, Day, Year) 22. Re	e of death (Item 23a) (Type exm Maryland A egistrar's Signature	ospital Levile	150350	rvatts Ke	sad, Llinton	MU20735
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ထ	or Its		1 Never Married 2 Marrie		¹ 01963−	1 ☐ Yes 2 No		1110411, 510.)		
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			C # 12 # 12 2 #	15,72	
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Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	Day Year
o.		ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	time of death 3			***************************************		
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Robert M. Koods, Jr. Proceedings				For State Registrar								5 33043
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Typicing Medical Examiner Primary Liver Failure due to Hepatitis C Sequential disease or condition (realing in death) Sequential disease or condition (real disease or condition (real disease or condition) Sequential disease or condition (realing in death) Sequential disease or condition (realing in death) Sequential disease or condition (realing in death) Sequential disease or conditio	Ball	permit. Depart Import any inj		21. Algrature of File of Service in	ensee lands	+	10	Name and Add	dress of Facility Si Eville Pil	imple Tril	oute ille, Ma	ryland 20852
Sequentially ist conditions, single-standard programs of the standard p				Immediate Cause (Final disease or condition	a. Primary	Liver	Fail				əst,	Interval Between Onset and Death
Type II Diabetes Mellitus Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. Primary Hepatocellular Carcinoma Type II Diabetes Mellitus Part II. Diabetes Mellitus Part III. Diabetes Mellitus Part III. Diabet			er	Sequentially list conditions,	cirrhos	is of t	he 1	iver				
Primary Hepatocellular Carcinoma 1 Yes Ye		te be executed ysician and e burial-transit		that initiated events	c. Due to (or as	a consequenc	e of):					
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Primary Hepatocellular Carcinoma 1 Yes Ye		ne death ce the attendi thed for use	ysiclan/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1⊡Live birth 4⊡Pregnant a	2 Fetal dea					1	
Type II Diabetes Mellitus 24a. Was an autopsy findings available prior to complete cause of death? 24b. Were autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy performed? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death? 24b. Were autopsy findings available prior to complete cause of death of the cause of Death (Check only one) 24b. Were autopsy findings available prior to complete cause of Death (Check only one) 24b. Were autopsy findings available prior to mainly autopsy fin	׆	ires that t signed by t be detac	by					derlying cause	given in Part I.			
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Manner of Death Natural Square Sq	E Ke	The la ate has page 2	Comp		s Mellitus					autons	v Drii	or to completion of cause of ath?
The standard of the standard o		sicien certifi	m	evaminer?	Hospital:	ant 20 cp//	Dutantia -	20000	Mar			(C
30. Name and address of pers. who completed cause of deal them 23a) (Type, Print) Phillip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832	Ö	y Sign	\vdash	27. Manner of Death	28a. Date of Inju	urv 28b	. Time of	3 DOA	4 🗀 Nursing	-		1.7 77
30. Name and address of pers. who completed cause of deal them 23a) (Type, Print) Phillip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832	Ö	anding vath. or: Afte	atlo	2 Accident investigation	tion	ly rear)	injury					
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30. Name and address of pers. who completed cause of deal them 23a) (Type, Print) Phillip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832		he Hospi n 24 hous he Funer pletely fill		(Check only 2 Medical Ex	aminer: On the basis of	of examination a	ige, death and/or inv	occurred at the estigation, in m	time, date and plac y opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
30. Name and address of pers. who completed cause of deal them 23a) (Type, Print) Phillip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832		with To t	Σ	29b. Signature and title of certifier								,
Phillip Henjum, M.D. 3416 Olandwood Court, #204, Olney, Maryland 20832				- KNOW	2				.2206	Se	eptember	24, 2005
									204. Olna	v. Marvla	and 2083	2
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			For State Registrar		State of	Marylan		artment rtificate				ental Hy	_	2005	33	Ոևև
				ame (First, Middle	Last)							2. Date of De Month			3. Time	of Death
	Physicia /Medic		Carol	yn Ma	rinari	Wo	ood							20, 20	05 5:3	8 P M
	Examin				give street and num	ber)				Location of			44	c. County of Dea	th	
		- 4		Bradford		Ago (In um	In a t hirth day.	Sil If Under 1		Spri	_	9 Date of Bis	Ala	Montgom		
П	Funeral Director		5. Social Security 579-12-0		1 M 2XTF	'. Age (In yrs. '8			Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year 24) ^{9.} 55 1918 It	thplace (Star ountry)	e or r-oreign
	יסי		Usual Residence					1				prii		131φ 10	ату	
	anylan show	-	10a. State	10b. County			y, Town or Lo									City Limits
	Ba-f	ecto	Maryland		jomery	S	ilver									es 2 No
	with ti	吉	10e. Street and 1	Number Bradford	Road			10f. Zip 0					10g. C	itizen of What C USA		
	72 hours after death with the Maryland neturel; or items 23e or 28a-f show iteal Examinationst bandiffed at	Funeral Director	11. Marital Statu		12. Was Dece	dent Ever in U.	.S. 13.			ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Am		,
9	or iter	표		arried 2 Marri	Armed For	No No			_			Rican, etc.)		Black, Whi		
03	ours a	d by	3 XWidowe	d 4 Divorced	If Yes, Give Year or Da	tes:		1□Yes 2	LXLNO	Specify:				Specify Whi	te	
21215-0036	"netu	Completed	(S _i	15. Decedent pecify only highes	s Education t grade completed)		(Give	dent's Usual kind of work DO NOT use	k done d	during mos	t of worki	ng	16b.	Kind of Business	/Industry	
12	withir ene. then	dwo	Elementary/Se	econdary (0-12)	College (1-	4or 5+)				"						
	illed Hygi other	a l	17. Father's Nan	ne (First, Middle, I	_ast)		по	memake	±r	18. Mothe	er's Name	(First, Middle	Maide	Own Hom n Sumame)	е	
ılar	uld be Jenta rked ric ev	To B	Genesi	lo Marina	ri					Ма	ry C	iociola	a			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other then "neturel; or items 23e or 28a-1 show any injury or other treumatic event, the Marical Examination at the multified at once.			Name/Relationsh	nip (Type, Print)			-					_	or Town, State,		
	and lealth m 27 her tr			ood/ Son		205 5				Driv		allasto Date		Pennsy		
JO.	Mit of F			2 X Cremation	3 Removal from S	1 6	Place of Dispo cemetery, cre	matory or oti	her plac	(a) S	Sept.		20c. I	Location - City or	Town, State	
Baltimore,	iit. Pa			on 5 ☐ Other (S _i) Funeral Service I		Met	ropolit					05	Ale	xandria	. Vir	inia
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	Pnysician		23a. Part1. Ent shock, or I Immediate Cau disease or cond	heart failure. List : se (Final	comp consthat cannot only of Acute	used the deat ich line.	th. Do not en	ter the mode	of dyin	g, such as				ver Spri	Approxid	nate Between nd Death
	/Medical Examiner		resulting in dea			oras a conseq oscler										ears
	uted 1 Insit	Examiner	Sequentially list if any, leading to cause. Enter U Cause (Disease	o immediate nderlying o or injury	Diabe	rasa conseq tes	цивасе ой).								15 Y	ears
ó	sician and burial-transit		that initiated ever resulting in dear	th) Last	c. Due to (c	or as a conseq	quence of):								-	
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9	artifica ing ph e as th	Med	IF FEMALE:		1								1			
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Me	23b. Was dece	12 months? 2 □ No		nth 2 ☐ Feta ant at time of c	al death 3[⊒Ectopic pre ⊒ Other (spe						23d. Date of de Month	Day	Year
S, P	es the	by		gnificant condition	ns contributing to de	ath but not res	sulting in the u	inderlying ca	iuse giv	en in Part I				use contribute t		
ord	w requir been si should	eted	Пурст	LIPIGEM	<u> </u>							-			robably 4	
Vital Record	e la has je 2	completed												prior to death?	utopsy findin completion o s 2 \(\sum \) No	gs available of cause of
/ita	i icien : Th certificate rector, pag	BeC	25. Was case re examiner?	eferred to medical			71-11-2			26. Place	of Deat	(Check only	one)			
of V	Physicien: this certific ral director,	2	1 Tes				ER/Outpatie		_	4 🗆 140			_	6 □Other (Spe	ecify)	
	ling P	lon	27. Manner of E 1 X Natural	5 Pendin	9	h, Day Year)	28b. Time o Injury	of 28	Bc. Injun Wor			28d. Describe	how inj	ury occurred		
Division	Attending r death. ector: After by the fune	ficat	2 Accider	6 Could	not be 280 Place	of Injury - At h	ome, farm, st			163 2 🗆	-	28f. Location (Street a	and Number or F	lural Route N	lumber.
Οį	in Sittle	Certification;	4 🗌 Homici	de determ	buildir	ig, etc. (Speci	fy)		, 0,,,,,			City or To				
	dospit t hour unere	edical C	29a. Certifier (Check only one)		g Physician: To the Examiner: On the ba and mann	isis of examina										e(s)
	To the h within 24 To the f complete	Me	29b. Signature	and title of certifie	1917	1.		29c.		e number				ate signed (Mon		
)	12		•	Ker	will fu	kun			D21	154			ept	ember 2	1, 200	15
	1 "		30. Name and a	address of person	who completed caus	e of death (Ite	m 23a) (Type	, Print)				'				
				ard E. Ru Month, Day, Year)	bin, M.D.	5530 egistrar's Sign	Wisco	nsin A	lven	ue, C	hevy	Chase,	ME	20815		
	Sta Regist				005	الله مي	400	Les .								

		1	For State Registrar	State	of Marylan		artment of F		and Me		jiene leg. No.	005	330	145
			Decedent's Name (First, Middle	e, Last)					2	. Date of Dea Month	ith	Voor	3. Time of	
н	Physicia /Medic		MIYUKI WEST						S	EPTEMB			1:11	A ^M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o		of Death					
			208 GRASONVILL 5. Social Security Number	E CEMETER 6. Sex	Y KOAD 7. Age (In yrs. i	last birthday)	GRASONV If Under 1 Year		24 Hrs. 8	. Date of Birth				r Foreian
	Funeral Director		556-08-3134 Usuat Residence of Decedent	1 ☐ M 2 🛣 F	79	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day PR. 2,	1926	Pay Year 21, 2005 Cac. County of Death QUEEN ANN P. Birth County of Death QUEEN ANN P. Birth County P. Birth C	hplace (State of buntry) PAN	
	ow ow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside Cit	ty Limits
	Many s-1 sh	tor	MD QUEEN	ANNE'S	GRA	ASONVII	LLE						1 🗆 Yes	2 X No
	th the	Director	10e. Street and Number			A	10f. Zip Code				10g. Citizen	of What Co	ountry?	
	ath wi		208 GRASONVILL				21638				USA			
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ▼ Mar	Armed F	cedent Ever in U. orces? 2 🕱 No	.S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Orig an, Mexican	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)				
920	urs af	þ	3 Widowed 4 Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2 📉 No	Specify:			Spe	ecify: A	SIAN	
21215-0036	within 72 hours after death with the Marylend ene. than "natural", or Items 23e or 28a-f show fra Modical Excentine must be notified at	Completed	15. Deceder (Specify only highe	t's Education)	16a. Deced	dent's Usual Occup	ation during most	t of working		16b. Kind o	of Business/	Industry	
2	nithin ne. han "	mple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	d)			OLDI	помп		
	filed w Hygiel Other tl		12 17. Father's Name (First, Middle,	(ast)		HOM	EMAKER	18. Mothe	er's Name (First Middle				
Maryland	d d la	То Ве	SHINJI SAKURAD							KNOWN)		,		
ary	should land Meniar Marke	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street				r, City or To	wn, State, 2	Zip Code) 21	1638
	and 2 ealth a n 27 ls		DAVID L. WEST/	HUSBAND				LE CE						
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from	20b. P	lace of Disponentery, created to the company of the	sition (Name of matory or other place E_CREMAT	TON	Dat	te	20c. Locati	on - City or	Town, State	
Ħ.	t. Pag rtmen rtent:		* 4 □ Donation 5 □ Other (S	pecify)	, ČEN	TER, I	LC.	; C	9/22/	2005	STEV	ENSVII	LLE, MD	
Bal	permit. Departr Importa any Inj		21. Signature of Funeral Service	Licensee	gett	F1	Name and Addre ELLOWS, H D6 SHAMRO	ELFEN	BEIN	& NEWN HESTER	AM FUI , MD			?.A.
	Pmysician :		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	each line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or i	respiratory ar	rest,		Approximate Interval Bety Onset and I	ween Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq								TH T INOM	June
	Examiner		Sequentially list conditions,	U.	CARDITIS		PERICARD	IAL E	FFUSI	ON			APPROX	
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	2	ONARY F		2						SEVERAI YEARS	_
Ć	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	U	(or as a conseq		J						TEARD	
8760,	cate be executed physician and the burial-transit	cai		d.										
9	artifica ing ph e as th	Physician/Med	IF FEMALE:											
Вох	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Feta	Ideath 3	Ectopic pregnancy	1			23d.			/ear
o.	that the death hed by the atter detached for u	ysic	1 □ Yes 2 X No 9 □ Unknown	9□ Unki	nant at time of d	eath 5	Other (specify) _							
<u>α</u>	res that igned by be deta	by Ph	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of d	eath?
rds	w requires been sig should b	ed b	ATRIAL FIBRILL	ATION						1 🗆 Y	es 2XN	o 3 Pr	obably 4 🗆	Inknown
ecords,	e law requ has been ye 2 shoul	Completed								24a. Wasa autop	sy	prior to d	topsy findings a	available ause of
$\mathbf{\alpha}$	Physician: The this certificate har all director, page	Соп								perfor		death?		
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Ott			Check only or				
ot		. To	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 1	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time o	IL 3LI DOA	4 110		 5 X Resid d. Describe h 			cify)	_
on	Attending F r death. sctor: After by the funera	ation	1 XNatural 5 ☐ Pendi 2 ☐ Accident invest	. 9	nth, Day Year)	Injury		rk? Yes 2 □	No					
Division	or Ifte	Certification:	3 Suicide 6 Could 4 Homicide determ	ained 200. Plat	e of Injury - At he ding, etc. (Specif	ome, farm, str y)	reet, factory, office		28	f. Location (5 City or Tow		umber or Ru	ural Route Num	ber,
	Hospita 4 hours Funeral ely filled	Medical C		ng Physician: To th Examiner: On the and ma)
	To the within 2 To the complet	Me	29b. Signature and title of certific	r _Λ /	100		29c. Licens	se number		2	29d. Date si	gned (Monti	h, Day, Year)	
			> Del	land	Z n	12	D323	353			0	9-2	1-05	
			30. Name and address of person DANIEL JAY KON					#107,	STEV	ENSVIL				
	Sta Registi		31. Date filed (Month, Day, Year SEP		Registrar's Signa									

			1 - State Registrar	State of Maryland / De	partment of Health and ertificate of Death		ene - N2005 33046
			Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death
	Physici /Medic		Raymond Robert	Werner		September	c 24, 2005 12:40P M
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	ith	4c. County of Death Howard
	F		14269 Triadelphia 5. Social Security Number 6. Se		Dayton ay) If Under 1 Year If Under 24 Hr		9 Birthplace (State or Foreign
	Funeral Director			XM 2□F 86 Yrs	Months Davs Hours Min		918 Ohio
	put		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Marylia f sho	lor	Maryland Howard	Dayton			1 □ Yes 2 □ No
	r 28a-	Director	10e. Street and Number	Dayton	10f. Zip Code	10g	. Citizen of What Country?
	23a o	al D	4998 Centaurus Co	urt	21036	US	SA
	er dea Items Der Fo	Funeral	11. Marital Status	Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Evertiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1943-47	1 ☐ Yes 2 🕅 No Specify:		Specify: White
21215-0036	72 hornatur	Completed	15. Decedent's Edi (Specify only highest grad		cedent's Usual Occupation ive kind of work done during most of w	orkina 16	b. Kind of Business/Industry
7	within ne. han "	mpi	Elementary/Secondary (0·12)	College (1-4or 5+)	e. DO NOT use retired)		efense Industry
р 5	filed Hygie other lend	Be Co	17. Father's Name (First, Middle, Last)	5+ Mech	anical Engineer 18. Mother's N.	ame (First, Middle, Ma	
<u>lan</u>	Aental Aental rked tic ev	To B	Edward R. Werner		Floren	ce Sitzens	tock
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship (T	ype, Print) 19b. M	ailing Address (Street and Number or I	Rural Route Number, C	City or Town, State, Zip Code)
e,	1 and Health 9m 27 ther to		Allison R. Friedr 20a. Method of Disposition		8 Centaurus Court		D 21036 c. Location - City or Town, State
ğ	ages ent of it: If It y or o		1 ☐ Burial 2 [X]Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State cemetery, of	crematory or other place) [56]	rember	denton, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Martical Evantical must be notified at once.		21. Signature of Funeral Service Licens		22. Name and Address of Facility Going Home Cremat:		
<u>m</u>	88 58		Devery & A	M01251	Beverly L. Heckro	te, P.A.	Clarksville, MD 21029
Ü				lications that caused the death. Do not ine cause on each line.	enter the mode of dying, such as cardi	ac or respiratory arrest	t, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ADVANCED DE	FMENTIA		GEARS
	Examiner		1	Due to (or as a consequence of):			
	₽ ≓	ner	Sequentially list conditions, lary, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical E		d			
9	5 6 8 E	Medic		0.			
Вох	death certifi e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	0 0 0	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Morall Day Feat
S, P	The law requires that the site has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	w require been sig should b					1 🗆 Yes	2 No 3 Probably 4 Unknown
Record	e law re has be je 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
						performe 1 ☐ Yes 20	d? death? XNo 1 ☐ Yes 2 ☐ No
Vita	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:		eath Check on one	e 6XOther (Specify)Living
Jοι		-	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim Injury	e of 28c. Injury at	28d. Describe how	
Sior	Attending r death.	catic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	,,,,	M 1 Yes 2 No		
Division	- 9	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 X Certifying Phy	vsician: To the best of my knowledge, d	eath occurred at the time, date and plan	e, and due to the cau:	se(s) and manner as stated.
	the Ho in 24 the Fu	ledical	one)	iner: On the basis of examination and/o and manner stated.			
	To vith	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
1			30. Name and address of person who d	ompleted cause of death (Item 23a) (Ty	D 5 1 8 6 0	Sej	ptember 26, 2005
1	E.G.		JONATHAN FISH	1 444	HARTER DRIVE #	ro Cou	MAIA MO 21044
	Sta Registi		31 Date filed (Month Day Year)	005 32. Registrar's Signature	Societi s		
	negisti	L.		1	KANRAES A		

		_	State Registrar	State of Marylan		rtment of tificate of			Rag. NZ UU5	33047
	Physicia /Medic		Decedent's Name (First, Middle, Last) LOWELL CONRAD YUN	D				2. Date of Dea	ath ER ^{Da} y8, 200	3. Time of Death 05:30 A м
	Examin		4a. Facility Name (If not institution, give single 10864 FORESTON RO.			4b. City, Town, CHESTER	or Location of De	eath	4c. County of D KEI	
	Funeral Director		5. Sociał Security Number 6. Sex 176-26-4741 1五	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birt in. DECEMBE	R6,1923 L	Birthplace (State or Foreign
	ס		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl	ctor	MD KENT		CHESTER					1 ☐ Yes 2 XNo
	3a or 28	i Director	10e. Street and Number 10864 FORESTON RO	AD		10f. Zip Code	21620		10g. Citizen of What USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-f show entry injury or other treumatic event, the Medical Exacting remains be notified at anote.	by Funeral	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U Amed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of f Yes, specify Cu	oan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, W	merican Indian, /hite, etc. WHITE
21215-0036	within 72 ho ane. than "netur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occu kind of work done DO NOT use retir PEDIC SI	during most of (ed)	working	16b. Kind of Busine	ss/Industry
Maryland 2	uld be filed Jental Hygis rked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) ROY L. YUND	31				Nam <i>e (First, Middl</i> e, H BRODE	Maiden Sumame)	
Mary	d 2 sho th and Iv 7 Is ma treuma		19a. Informant's Name/Relationship (Type RUTH YUND/WIFE	oe, Print)	1				er, City or Town, State	
Baltimore,	Pages 1 an nent of Heal ant: If item 3 ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, cren	sition (Name of natory or other pl	ace)	Date	20c. Location - City STEVENSVI	or Town, State
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service License	(he)	FF 13	Name and Add	ess of Facility HELFENBE ROAD, C	IN & NEWN	AM FUNERAL	L HOME, P.A.
			23a. Part1. Enter the disease, or combine shock, or heart failure. List only on Immediate Cause (Final	eations that caused the dear e cause on each line.		er the mode of dy	ing, such as card	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	uence of):	E HI	EANT A	factor.	6	-1-
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec		TIFE	B Des	YM		73yr1
68760,	ficate be executed physician and is the burial-transit	edicai	La							
.O. Box	that the death certifi ed by the attending I detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mmths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of o 9 Unknown	al death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	delivery Day Year
S, D	sign sign d be	by	Part II. Other significant conditions coa	tributing to death but not res	sulting in the u	nderlying cause g	iven in Part I.			e to the cause of death?
al Record		Completed						24a. Was autop perio 1 \(\subseteq Yes	prior rmed2 death	autopsy findings available to completion of cause of 1? es 2 No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatier	nt 3 T DOA	thor	Death (Check only o	<i>ine)</i> dence 6 ⊟Other (S	ipecify)
ion of	ding I. After fune	ation; T	27. Mann. of Death 1 Z latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj			now injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	i i i i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, Jarm, str fy)	eet, factory, office		281. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,
	e Hospital 24 hours a e Funeral I	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	nician: To the best of my known ar: On the basis of examinating and manner stated.	owledge, deatl ation and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death o	ace, and due to the courred at the time.	cause(s) and manner date and place, and o	as stated. due to the cause(s)
t.	To the within 2 To the complet	Me	29b. Signature and title of ce lifier				ise number		29d. Date signed (M	onth, Day, Year)
/ ,	5		30 Name and address of person who co	mpleted cause of death /lta	m 23a) (Tvne	Print)	6054		7/291	05
	0+19-12 St		31. Date liled (Month, Day, Year)	Shancha 32. Restrar's Sign	0 18	Spa Ospa	er R	1 Ches	tertain	md 21620
*.	Regist			05 Keen	J. A	parte				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner WICOM LAKE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/14/1921 Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday, **Funeral** Days Min 1 □ M 2 XF 83 RI 036-12-2452 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at 1 ☐ Yes XXVo Director Worcester Ocean Pines MD 7.28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 22 Ocean Parkway USA or items 23a 21811 death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Administrative Assistant Government 4 Pages 1 and 2 should be filed v riment of Health and Mental Hygie rtant: if Item 27 is marked other t jury or other traumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christina R. MacPherson Frederick Whiteside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Ocean Parkway Ocean Pines, MD 21811 Chester Thomas Yates(husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Cape Henlopen Crem. 09/25/2005 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the shock, or heart trillure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** DRSRACE ZHRINIRRS 2 4RS. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical sete hes been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 XNo 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSVICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Duath 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a
To the Funeral C 29a. Certifier Certifving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DC052410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS 26266 GHULAM OWNEDD CT. 31. Date filed (Month, Day, Year) State 2005 Registrar

			For State Registrar	State of N	Maryland /		rtment of F	lealth and f Death	•	giene	5 33049
	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Decedent's Name (First, Middle, La	st)					2. Date of De	ath	3. Time of Death
	Physicia		Mabel	E.		P	dams		Month	9 Day 20	05 11.06AM
	/Medic Examin	-	4a. Facility Name (If not institution, giv	e street and numbe	r) .		4b. City, Town, o	r Location of Death)	4c. County of	
		51-	Franklin Squa	re Hos	spital		Rose	Jale		Balti	more
	Funeral		Social Security Number 6. 5	6ex 7. A I□M 2/XIF	Age (In yrs. last b		If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplace (State or Foreign Country)
A.	Director		213 30 3037	XA.	90	Yrs.			7-10-		Va.
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation				10d. Inside City Limits
	Marylan febow	ğ	Md. NA		,	Ralti	more				1 ⊋Yes 2 □ No
4	1 he	Director	10e. Street and Number	•		Darc.	10f. Zip Code			10g. Citizen of Wh	at Country?
	h with	0	3324 Ravenwood A	ve.			212	13		USA	
	ours after death with the Maryla rel', or Iteme 23e or 28e-f ehov Examinar mant be mutilied at	Funeral	11. Marital Status	12. Was Deceder Armed Force		13. V	as Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		American Indian,
မှ	or Ite		1 Never Married 2 Married	1 Yes 2			Tes, specify cubi	Specify:	o rican, etc.)	Specify:	White, etc.
5-0036	n 72 hours aft	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates	5:			Opocny.		Specily.	Black
20	be filed within 72 ho tral Hygiene. od other then "natur event, the Madical	Completed	15. Decedent's E (Specify only highest gr		16	(Give I	ent's Usual Occup ind of work done	during most of wor	king	16b. Kind of Busi	ness/Industry
2121	withir	d L	Elementary/Secondary (0-12)	College (1-4o	or 5+)		ONOTuse retire nestic	<i>a)</i>		Other D	eople Homes
42	Hygie ther int.		12th grade 17. Father's Name (First, Middle, Lasi)			IESCIC	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "naturel", or Items 23s or 28s-f show eumatic event, the Modical Examiner must be notified at	To Be	Llovd		Matthews			Mary		Burnet	
Z Z	shou nd M mar	-	19a. Informant's Name/Relationship			b. Mailin	Address (Street		iral Route Numbe	er, City or Town, St	
~ \Z			Michelle Cheatha	ım Grandda	aughter	7 1	Blue Hero	on Ct., E	Baltimore	e, Md.	21220
&β more,	ges 1 and 2 should t of Haaith and Mer If item 27 le marke or other treumatic		20a. Method of Disposition		como	of Dispos	ition (Name of atory or other pla	ce)	Date	20c. Location - C	ity or Town, State
_ \lambda \mathbb{E}	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		19	-	int Cem.		12-05	Baltimo	ore,Md.
Adam Saltimore,	permit. Pages 1 and: Department of Haalth Important: If item 27 eny injury or other tr		21. Signature of Funeral Service Lice	nsee		2411	Name and Addre	ess of Facility	Baltimo	ore, Md.	21202
	89889		Dondon 11	MWIN		1	March F.	H. East	1101	E. North	
* * * * * * * * * * * * * * * * * * *			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus one cause on each	sed the death. Do n line.	o not ente	r the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MI							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequenc	e ol):					
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289		edlo		_ u.							
Box 6	n cert anding use a	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						23d. Date	ol delivery
m.	uires thet the death certific signed by tha attending c d be detached for use as	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 Fetal dea t at time of death		Ectopic pregnanc Other (specify) _	у		Monti	h Day Year
P.O.	et the by th	hys	9 Unknown	9□ Unknown							
Ś	es th igned be de	by £	Part II. Other significant conditions	(100	- ' 0						oute to the cause of death?
ord	w require been si should I	ted	Chy Humier	101017600	rein, vei	et v	ein In	rom bosis	1	Yes 2□No 3	Probably 4 Junknown
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=	ilcian: The lav certificate has rector, paga 2	Š							1 ☐ Yes		ath? ☐ Yes 2 ☐ No
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o	Phys this ral di	7	1 Yes 2 No 27. Manner of Death	1 Linpa		Outpatien Time of	3L DOM			dence 6 Other	
on	ding P. h. After funera	ton	1 Natural 5 Pending □ Accident investigate	28a. Date of li (Month, i	Day Year)	Injury	28c, Inju Wo M	rk?]Yes 2∐No	200. 1000	now injury occurred	
isi.	Atten deal ctor: y the	fica	3 Suicide 6 □Could not		Injury - At home, etc. (Specify)	larm, stre			281. Location (Street and Number	or Rural Route Number,
ē	a after	Certification:	4 Homicide	building,	etc. (Specify)				City or To	wn, State)	
	ospit hour unere ly fille		29a. Certifier 1 Certifying P	hysician: To the be	est of my knowled	lge, death	occurred at the ti	me, date and place	and due to the	cause(s) and mani	ner as stated. id due to the cause(s)
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, paga 2	Medical	one)	and manner	stated.	ariozor iriy			med at the time,		
	To To	2	29b. Signature and title of certifier	4	_ (29c. Licen:	se number	9	29d. Date signed	(Month, Day, Year)
	1		Maura /	Milon) _		100	0 6261		10/9/0.	5
	2		30. Name and address of person who	completed cause	death (Item 23a	(Type.)	rint)	co or.	Vo Bal	timare M	10 21231
	Sta Sta	te	31. Date filed (Month, Day, Year)	#. Regi	istrar's Signature	Ann	The state of the s	111	· E pool	· · · · · · · · ·	11 01 //
	Regist		31. Date filed (Month, Day, Year)	05 Berly	w B.	19					
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				State of Maryland / Department of Health ar 1 - State Registrar Certificate of Death	nd Men		ene 2005	33050
		Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death (6:15 PM
		/Medio Examin		Baby Girl Abayneh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death		4c. County of Dee Baltimo	th
		Funeral Director		Franklin Square Hospital Center + Ose doule 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24 Nonths Days Hours 1. Age (In yrs. last birthday) Yrs.	Min.	Date of Birth Month, Day, 1	(ear) 9. Bir	thplace (State or Foreign ountry)
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		death with the Maryland ms 23a or 28a-f ahow f.reust be notilited at	Director	MD Harford Edgewood 10e. Street and Number 10f. Zip Code		1 10	g. Citizen of What Co	1 ☐ Yes 2 ₹ No
		h with 1	ai Dir	10e. Street and Number 410 Blue Heron Court 2104	0	101	USA	ountry:
	36	n 72 hours after death with the Maryla "natural", or Itams 23a or 28a-f ahov golical Examinar must be nostifiad at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	in? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whit Specify:	
1sik	Maryland 21215-0036	within 72 hou ene. than "natura he Modical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	of working	16	6b. Kind of Business	Andustry
200	121	ited wit Hygiene Ther tha	Соп	none none none	's Name /Fi	ret Middle Ma	none	
Babygir	ylanc	ges 1 and 2 should be lited within it of Health and Mental Hygiene. If item 27 Is marked other than " or other traumatic event, the Med	To Be	Meser	et Ab	ayneh		
	Mar	Ith and 25 ls m		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number</i> Franklin Square Hospital 9000 Franklin Squar				
bay neh,	Baltimore,	permit. Pages 1 and 2 of Depertment of Health at Important: If item 27 is any injury or other traugone.		20a. Method of Disposition 1 Buriat 2 Cermation 3 Removal from State 1 Donation 5 Dother (Specify) in state	Date		Oc. Location - City or	
Ab	Balt	permit. Departr Imports any infe		21. Sign turn of Euneral Spryice) censee Rona Ld Wade, Director State Anatomy Bo Baltimore, MD 2	oard 6. 21201	55 W. I	Baltimore	Street
•		Physician /Medical		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as constant, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ### ### ############################	ardiac or re	spiratory arres	st,	Approximate Interval Between Onset and Death
	8760,	Examiner physicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	re ma	turitu	<i>-</i>	
	P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific: within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	livery Day Year
	rds, P	quires that in signed build be deta	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did toba		o the cause of death?
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	Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
		ne Hospit n 24 hours ne Funera	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.				
		To tl withi To tl	Σ	29b. Signature and title of certifier 29c. License number D5389/			d. Date signed (Mon 10 ~ 6 - 0	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Drive	h. 14	nace 1/1 7	1727
		St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 3 2005 OCT 1 3 2005	VIIVE,	1)a 1111	more, MRS Z	1601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 1 per phys. 2848 10-13-05 vt. State of Maryland Department of Health and Mental Hygiene 2.0.0

1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) Ballard 2. Date of Death Amantha Louise Day Month Year **Physician** October 8 2005 /Medical unknown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD CO 111 CHELL ROAD JOPPA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 85 Yrs Director 184-12-3040 OCT 25 1920 PENNSYLVANIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🛛 No Be Completed by Funeral Director MARYLAND JOPPA HARFORD CO 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 111 CHELL ROAD 21085 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X Vo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: Specify: BLACK 3 □ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade CLERICAL ASSISTANT ADMINISTRATION Pages 1 and 2 should be filed withen of Health and Mental Hygiestant: if Item 27 is marked other tigury or other traumatic event. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALEXANDER MITCHELL ဂ္ ELIZABETH BOSTON 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cornish/Daughter 111 Chell Rd., Jopa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: if any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) WILLIAM H DAY CEMETERY 10-13-05 Steelton, PA. 21. Signature of Funeyal Service License 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. laru 321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nyocardial **Physician** /Medical Due to (or as a consequence of) Examiner Preholusura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit pertersion Box 68760. physician iahete for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> cate has been sig 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide Hospital 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) washed rd Bel Aw, mn 21014 31. Date filed (Month, Day, Year) 611 Mcille 32. Register's Signature State Registrar

			1 - For State Registrar	State of I	Maryland / Dep	ertificate of		and Me		iene g. 200	5	33052
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			6848 B&A Blvd.			Linthio		Odline I.		Anne A		
	Funeral Director		5. Social Security Number 226-40-2478	6. Sex 7 1⊠ M 2□ F	Age (In yrs. last birthday 71 Yrs.	Months Days		Min.	Date of Birth (Month, Day, L2-25-1	Year) 933	9. Birthp Cour	place (State or Foreign ntry)
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	Maryla f ehov	ior		rundel	Linthicu						'	0d. Inside City Limits 1 ☐ Yes 2 🐴 No
	or 28s-	Director	10e. Street and Number	runger	LINCHICU	10f. Zip Code			10	Og. Citizen of W	hat Cour	ntry?
	ath wil		6848 B&A Blvd.			21090				.S.A.		
	within 72 hours after death with the Maryland ene. Than "hetural", or items 23a or 28a-f ehow ha Mudical Ezandrar nual ter notified at	Funeral	11. Marital Status 1 Never Married 2XMarried	12. Was Decede Armed Force ied 1 ☐ Yes 21	s?	Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		- Americ k, White,	ean Indian, etc.
99	ours al	þ	3 Widowed 4 Divorced	If Yes Give		1 ☐ Yes 2☑ No	Specify:			Specify:	Wh	ite
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212	d within	ошо	Elementary/Secondary (0-12)	College (1-4d	or 5+)	sel Mecha				Autom	otiv	e
Maryland 21215-0036	pe filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle,		· · · · · ·		18. Mother	r's Name (F	First, Middle, N	Maiden Surname	э)	
<u> </u>	d Meni d Meni narke	2	Lawton Samuel 19a, Informant's Name/Relations		40h Adai	line Address (Charles		La Smi		O'the set Town	C4-4- 7'-	0.11
	ulth and 2 si		Betty Bowers /			ling Address <i>(Str</i> ee 8 B&A B1s					state, zip	Code)
altimore,	of Health of Health Fitem 27		20a. Method of Disposition P⊠Burial 2 □ Cremation		20b. Place of Disp			Date	-	20c. Location - 0	City or To	wn, State
Ĕ	. Page tment tant: ff jury o		`4 □Donation 5 □ Other((S	(pecify)	Glen Have	en Memori	lal PK		-2005	Glen B	urni	e, MD
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<u> </u>	sician certifi irector	o Be	25. Was case referred to medica examiner? 1 \sum Yes 2 \sum LNO	Hospital:	atient 2 ER/Outpatie	ent 3 DOA	thor		Check only one	nce 6 □Othe	. (0:4	
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			Wymae	My Atten	dung Ocotes	1 0	2160	54		10-	12-	2005
	4		30. Name and address of person C·V·CYRIAC 31. Date filed (Month, Day, Year)	who completed cause of M·D 80	of death Mem 33a) (Type	H16 10	NY, 1	DASA	ADENA	MD	2	1122
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	1- For State of Maryland / Department of Health and Mental Hyg 23a per Dr., G848 Leftificate of Death	
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Funeral Director	15. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Usual Residence of Decedent	
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permit. Pag Department important: any injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility III VIERY Security Community 3443 Charles 57. Bac	D. Cromartie 7/5
Provided American Ame	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. End Stage Renal Disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Pulmonary Embolism	rest, Approximate Interval Between Onset and Death
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To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	29a. Certifier (Check only one) 29a. Signature and title of bertifier 29b. Signature and title of bertifier 29c. Certifier (Check only one) 29c. License number 29c. License number	
12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL T. 1401+2 UNIVERSITE IN MICHAEL 22 S. C.	Sept, 24 2005 Greene St Balti Md 2
State Registra		fixens parting i

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician Harriet Bowen October 0 2005 8:35 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Harbor Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 5, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 70 Director 216 32 8935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S. 1616 Cypress Street 21226 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 P Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be filt Deportment of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 2008. Be Mary Elizabeth Jones John Link Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorun VanSkiver / Daughter 1616 Cypress Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 10/11/2005 Baltimore, Maryland Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 amirous 2 a. Part1. Enter the diseas shock, or heart failure. I s of of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIO PULMONARY **Physician** /Medical Examiner SEUMONI fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed use as the burial-transit SI siclen and Division of Vital Records, P.O. Box 68760, UCHOGENIC CARCINOUS Completed by Physician/Medical ettending phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the ette d be detached for Year Month 4☐Pregnant at time of death Day 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2□ No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Predical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical 29d. Date signed (Month, Day, Year) 29b 9 ignature and le of certifie 29c. License number 10/10/05 completed cause of death (Item 23a) (Type, Print) tchie Huy. Brooklyn Pork 21225 TLEGAR strar's Signature 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrar	State of N	laryland /	Depa <i>Cer</i>	irtment of tificate of	Health a	and M	lental Hy	giene 2	005	33055
	Physicia		1. Decedent's Name (First, Middle, Last) Harry T. Crawford							2. Date of Dea Month Octobe	ath Day	Year 2005	3. Time of Death 12:50 P
	/Medic Examin		4a. Facility Name (If not institution, give s Berline Nursing δ	treet and numbe			4b. City, Town, Ber1			occobe	4c. Cou	unty of Death	
	Funeral Director		214-22-3343	M 2□F	Age (In yrs. last b	irthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da May 24		9. Birth Coul Mary	place (State or Foreign ntry) rland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County DE Sussex		10c. City, Tov								10d. Inside City Limits 1 ☐ Yes 2☐ No
	th with the 23a or 28s	al Direc	10e. Street and Number 113 E. Shady Dri	/e			10f. Zip Code	9975			10g. Citizen	of What Cou	ntry?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deceder Armed Forces 1 Types 2 I If Yes, Give Year or Dates	s?] No		Vas Decedent of f Yes, specify Cu ☐ Yes 2 No			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ^{ecify:} whi	etc.
, Harry T. aryland 21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation	168	(Give life. L	lent's Usual Occi kind of work don OO NOT use retir uperviso	e during mos red)	st of work	ing		of Business/In	,
Harry	wild be filed Mental Hygi srkad other stic event, t	To Be Co	17. Father's Name (First, Middle, Last) Harry Talbert		1		арст v 130			e (First, Middle, garet L	Maiden Sur	name)	
יס ≥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.		19a. Informant's Name/Relationship (Ty, Arlene Crawford/sp 20a. Method of Disposition	ouse	20b. Place	113 of Dispos	g Address (Street E. Shad sition (Name of natory or other pl	y Driv	e	a <i>l Route Numbe</i> Se1byvi Date	11e, I	725	75
Crawfor Baltimore,	permit. Pages Department of I Important: if its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Soccify) 21. Signal re 1 Eureral Service Utense	1	rector	22	Name and Add ate Ana Itimore	ress of Facili		,655 W.	Balti	lmore S	Street
	Physician		23a. Part 1 Enter the disease, or combine shock or heart failure. List only or Immediate Oeuse (Final disease or condition	ations that caus e cause on each	ed the death. Do								Approximate Interval Between Onset and Death
8760,	ate be hysicie the bur	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequence	ンシが e of):	re Hive	Puli	ucri	y Dis	STURE		Years
Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal deat at time of death		Ectopic pregnan Other (specify)	су			23d.	Date of delive	ery Day Year
rds, P.	en signed by		Part II. Other significant conditions cor	tributing to death	but not resulting	in the ur	nderlying cause g	given in Part I	l. 	M.	obacco use d	20	ne cause of death?
al Reco	a a a	Completed								24a. Was autop perfo 1 🗆 Yes	rmed?	b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
Division of Vital Records, P.O	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ion: To Be	27. Manner of De th	ospital: 1 lnpa 28a. Date of Ir (Month, L		Outpatien Time of Injury	28c. Inj	other: No	ursing Ho	n <i>(Check only o</i> me 5 ☐ Resid 28d. Describe h	lence 6 🗆	1-1-	y)
Divisio	al or Attencater death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At home, etc. (Specify)	farm, stre	-			28f. Location (S City or Tow	Street and Nu m, State)	mber or Aura	al Route Number,
	the Hospita in 24 hours the Funeral pletely filled	Medical C	one)	icien: To the be ner: On the basis and manner	of examination a	ge, death and/or inv	occurred at the restigation, in my	time, date ar opinion, dea	nd place, ath occur	and due to the deed at the time, of	cause(s) and date and pla	manner as s ce, and due to	tated. the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	leel			29c. Licer	1876	7		29d. Date sig	gned (Month)	Day, Year)
	• 0		30. Name and address of person who co	Dorochu	f death (Item 23a) (Type.	1209	Celes	fel	Hefur	a, F	Cew !	et Isled
	Sta Registr		OCT 1 3 200	0	w B	Con	when			7			

				Department of U		•	•	
		1 _ For State	State of Maryland /			dental Hygier	2005	33056
		Registrar		Certificate of I	Jeath	Reg. I	NG 000	
Physic	ian	1. Decedent's Name (First, Middle, Last) JAMES (CAUTHOR	KE			Day Year	3. Time of Death
/Med		4a. Facility Name (If not institution, give s			Location of Death	7	- 28 200	
Exami	ner	BON SECOURS			TMORE		4c. County of Death	
Funoral		5. Social Security Number unk 6. Sex		birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Funeral Director		1 X	M 2□F 54	Yrs. Months Days	Hours Min.	Jan 1, 19	951 Vir	place (State or Foreign intry) ginia
P		Usual Residence of Decedent						
arylar show		10a. State unk 10b. County	unk 10c. City, To	own or Location			unk	10d. Inside City Limits
8a-f	cto		1101					ınk¹□Yes 2□No
vith th	Director	10e. Street and Number	unk	10f. Zip Code		unk 10g.	Citizen of What Cou	intry?
s 23g	by Funerai		IO Was Deserted Course III C	140 144 15	0.0000000000000000000000000000000000000		USA	
ter de Item	ű	11. Marital Status 1 ☑ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
urs af	by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	black
IN CILISIONS flied death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23e or 28e-f show ont, the Medical Franting must be rotilized.	Completed	15. Decedent's Educ	cation 16	Sa. Decedent's Usual Occupa	ation	. 16b.	. Kind of Business/l	ndustry
thin 7	ple	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	turing most of work)	ing		
A will	Con	unk ur		truck d	river		transpor	tation
Id be file ental Hy ked oth	Be	17. Father's Name (First, Middle, Last)		unk		e (First, Middle, Maid		
yla ould i Men Men arke	10				Mar	y Cauthori	ne	
Mar d 2 sh d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street a				p Code)
E, I		Karen E. Cauthorne 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	1825 W. North of Disposition (Name of				
DAILIMOTE Dermit. Pages 1. Department of He mportant: If Iten sny injury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State ceme	tery, crematory or other place		Date 20c.	Location - City or 1	own, State
ILIN it. Pa rtmer rtent njury		'4 □ Donation 5 ☒ Other (Specify)		00.11				
DESILITIONEY, MISTYIETHO ZIZIO-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at any once.		21. Signature of Funeral Service License Ronald S. W	ade, Director	22. Name and Address State And	atomy Boa	rd 655 W.	Baltimor	e Street
_		23a. Part 1. Enter the disease, or complic	cations that caused the death. D	Baltimore				Approximate
		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			or respiratory arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	SEPTIC	EMIA				
Examiner			SEPTIC Due to for as a consequence REWAL	FAILLYS	2F			
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence					
uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events						
O, exec an an rial-tr		resulting in death) Last	Due to (or as a consequence	e of):				4
OX DO/OU, certificate be executed nding physician and use as the burial-transit	cal							
ntificate ng phy as the	Med	IF FEMALE:						
BOX 6	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea	th 3 □Ectopic pregnancy			23d. Date of deliv	- /
e death the atter	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			Month	Day Year
that the		Part II. Other significant conditions con	tributing to death but not regulting	in the underhand source and	na in Dant I	220 Did tehana	o use contribute to	the serves of death?
	l by	atti. ottioi sigimouti oottattoiis con	thouling to doubt but not resulting	3 at the discerning cause give	minraiti.	1 Yes		bably 4 Junknown
o be led	etec							
e lar has	ompieted					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
T T	O					1□ Yes 2⊡1		2 No
	o Be	25. Was case referred to medical examiner?	ospital:	Othe		h (Check only one)		
	}	1 Yes 2 No		Outpatient 3 DOA D. Time of 28c. Injury	4 ☐ Nursing Ho	me 5 Residence 28d. Describe how in		(y)
VISION C Attending P or death. ector: After t by the funera	tion	1 atural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work	(? Yes 2□No			
Attending r death. sctor: After oy the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office		28f. Location (Street		al Route Number,
s afte	Certification:	4 Homicide	building, etc. (Specify)		Į.	City or Town, St	ate)	
bspit hours unere		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	lge, death occurred at the tim	ne, date and place,	and due to the cause	(s) and manner as	stated.
he Hin 24 he Fi	edical	(Check only 2 Medical Examir one)	ner: On the basis of examination and manner stated.	and/or investigation, in my of	oinion, death occur	red at the time, date a	and place, and due	o the cause(s)
To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att	Σ	29b. Signature and title of certifier	n A	29c. License			Date signed (Month,	
		Kepidn K	. con	n.) Dod	20277	5-	eptembe	28, 2005
		30. Name and address of person who co	mpleted cause of death (Item 23a	a) (Type, Print) BOK	1 5=61	140C 1	trem +	28, 2005
	201	31. Date filed (Month, Day, Year)	32. Segistrar's Signature		7 2200	MAS 1	, spilk	
S Regis	taté trar	DCT 1 3 20		Goods				

RICARDO CALDERON 05-06536 RKD

Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend 1tem/23a, 27, 28a-f, perME, G848, 10/15/05 TT

3	Funeral Director		5. Social Security Numberunk 6. S	9x 7. A	ge (In yrs. last birti 54	rday) If Un Monti	der 1 Year ns Days	If Under 24 Hrs Hours Min.		th y, Year) , 195	9. Birti	nplace (State or Foreign untry) UNK
7	deeth with the Maryland me 23a or 28a-f show r must be notified at	_	10a. State 10b. County		10c. City, Town						-	10d. Inside City Limits
	the Maryla 28a-f shor	Director	MD 10e. Street and Number			Baltim	Ore Zip Code	_		10- Citi-	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1√ Yes 2 No
	3a or	ā	107 W. Saratoga S	troot		101.		21201		Tog. Citize	en of What Co USA	unary r
1	deetr	Funerai	11. Marital Status unk	12. Was Decedent	Ever in U.S.	13. Was De			specify Yes or No to Rican, etc.)	- 14	4. Race - Ame Black, White	
36	urs affer ai', or itu Examine	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Dates:	No unk		2 No	Specify:	10 7 1001, 010.7	ì	Specify: wh	
2-00	uatura Ical E	ted	15. Decedent's Ed	lucation		Decedent's U	sual Occupa	ation during most of wo	unk	16b. Kind	d of Business/l	ndustry unk
Maryland 21215-0036	within 72 hours after ene. than "natural", or ita ha Medical Examina	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	Tuse retired,)	i Airig			
nd 2	should be filed wit nd Mental Hygien i marked other thu umatic avent, the	Be	17. Father's Name (First, Middle, Last)	IIIK			unk	18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	unk
ıryla	s 1 end 2 should f Heelth and Men item 27 is marke other traumatic	2	19a. Informant's Name/Relationship ((vpe. Print)	19b.	Mailing Addr	ess (Street a	and Number or Ri	ural Route Numbe	ar City or	Town State 7	in Code)
Z S	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		O.C.M.E.	, p=1 · · · · · · · · · · · · · · · · · · ·	1	-			nore, MD	212		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Baltimore,	permit. Pages 1 en Depertment of Heeli Important: If Item 2 any injury or other ODES.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify	Removal from State	1	Disposition (i	Name of or other place	8)	Date	20c. Loca	ation - City or	Fown, State
Balt	permit. Depertr imports any infe		21. Signature Funeral Servicer icer	Wade, Vir	ector	State Balti		-	1 655 W.	Balt	imore S	Street
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each	d the death. Do n line.					rrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Head Ir	juries	f)·						
E	Examiner		Sequentially list conditions	b								
1	red	Examiner	Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury	Due to (or as	s a consequence o	ti:						
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68760,	ncate be physici s the bu	edical		d								
P.O. Box 6	Ine law requires that the death certifite hes been signed by the ettending vage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐Ectopie 5 ☐ Other	pregnancy (specify)			23	3d. Date of deli Month	very Day Year
ds, P	pures that n signed build be deta	Ď	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlyin	g cause give	en in Part I.		obacco uso Yes 2 🗆		the cause of death?
Division of Vital Records,	The law requir cate hes been si page 2 should	Completed									24b. Were autoprior to death?	topsy findings available ompletion of cause of
/ital	certificate	Bec	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o			
of \	Physi- this c ral dire	2	1 XYes 2 No	Hospital: 1 Inpati		patient 3	_	4 Nursing F	lome 5 Resid			
ion	Attending Physician: r deeth. sector: After this certific: by the funeral director.	ation	1 □Natural 5 □ Pending 2 □ Accident vinvestigation	7/21/20		jury unk		res 2. X No	200. Describe t	iow injury	occurred (ЦК
Divis	i i i i i	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ⚠ Could not be determined	286. Place of Ir	ijury - At home, far tc. <i>(Specify)</i>	m, street, fac	tory, office		28f. Location (S City or Tov	vn, State)	Number or Ru. 107 W	ral Route Number, Saratoga MD
:	ne Hospital n 24 hours a ne Funerel E stetely filled	edical	(Check only one)	ysician. To the besi niner: On the basis of and manner s	of examination and	death occum Vor investigat	ed at the tim ion, in my op	e, date and place pinion, death occu	e, and due to the erred at the time,	cause(s) a	ino manner as	stated.
,	To the within 2 To the comple	ž	29b. Signature and trill of certifier	·			29c. License	number		29d. Date	signed (Month	, Day, Year)
		- 5	> Coult	/)		0.C.	M.E.		SEPTE	EMBER 26	6,2005
			30. Name and address of person who	completed cause of	death (Item 23a) (PENN	STREET 1	BALTIMOR	E MAR	YI.AND 1	21201

			For State Registrar	State	of Maryl	and / Dep	artment o					005	33059
2	4		Decedent's Name (First, Middle	Last)						2. Date of Dea		000	3. Time of Death
	Physicia		KATHERINE	NARI	ARET	CA	STAGN	ETTI		Cetaber	Day	2005	16:36 M
	/Medic Examin		4a. Facility Name (If not institution						tion of Death			ounty of Death	10 30
	4		Johns Hopkins H	ospital			Balt	imore				NA	
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h V Yearl		place (State or Foreign
	Director		215-18-6521	1 □ M 2 😾	F 8:	Yrs.	MONUS	ays 1100	AIS IVIII).	Oct. 20			ryland
	pu 🌬		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Le	ncation						10d. Inside City Limits
	shor	٥											1 ☐ Yes 2 ☐ No
	the N	ect	Maryland Baltin	nore		Rose Dal	.e 10f. Zip Co	ada			10a Citizar	n of What Coul	
	with a or	by Funeral Director	9535 Devonwood	Court			212				rog. Onizor	U.S.	
	ns 23	era	11. Marital Status	12. Was [Decedent Ever i	n U.S. 13.			c Origin? (Spe	ecify Yes or No	- 14.	Race - Americ	can Indian,
' O	fter d	Fun	1 Never Married 2 Marri	ed 1 TY	l Forces? es 2X No				xican, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.
21215-0036	al', o	by	3 Widowed 4 □ Divorced	If Yes Year	, Give or Dates:		1□Yes 2x	JNo <i>Spe</i>	ecity:		Sp	pecify: Whi	te
5-0	72 hc	Completed	15. Decedent (Specify only highes		ed)	(Give	dent's Usual C	done durina .	most of work	ina	16b. Kind	of Business/In	dustry
2	ithin	npje	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)	life.	DO NOT use	retired)		9	7.1		0.55
2	ygier ygier her th	S	8	NA	A	Secr	etary	40.14	4 - N N	/F: N/		icians	Office
ng	be fi	Be	17. Father's Name (First, Middle, a John	Leo	Ç,	chmuck S	r		oretta	e (First, Middle,	маюн Би		Naney
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Maryland	2 an				(Can)	Total Control					ŕ		
	1 and Health tem 27 other tr		Robert J. Casta 20a. Method of Disposition	gnetti	(SON)	b. Place of Disp	sition (Name	of		Baltimo: Date	20c. Locat	tion - City or To	own, State
D D	Pages nent of I int; If ite		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		om State	cemetery, cre	-		Octob	erol4,	Twings	s Mills	, Maryland
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	9		23a. Part1. Ehter the disease, or shock, or heart failure. List	complications th	caused the con each line.	leath. Do not en						laiylan	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	K	VPOLIA								Onset and Death
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<u>ж</u>	The ate h page	Con								perfo	rmed2 2 No	death? 1 ☐ Yes	
/ita	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?					-		n (Check only o			
of	Physi this c	2	1 ☐ Yes 2 ZNo 27. Manner of Death	Hospital:	I Inpatient	2 ER/Outpatie				me 5 Resid			(y)
n	Jing I	ion	1 ☑Natural 5 ☐ Pendin	g (/	Month, Day Yea	r) 28b. Time of Injury	M 280	. Injury at Work? 1 ☐ Yes :		28d. Describe h	iow injury o	ccurred	
Division	Attanding r death. sctor: Afte	lical	2 Accident investig	not be	lace of Injury - /	At home, farm, st				28f. Location (5	Street and N	lumber or Rura	al Route Number,
Ω	after after Direct	Certification:	4 Homicide	b	uilding, etc. (Sp	ecify)	,			City or Tox	m, State)		
	e Hospital or 24 hours afte a Funeral Dire etely filled in b					knowledge, dea							
	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical one)	and r	ne basis of exam	nination and/or ir	ivestigation, in	my opinion,	, death occurr	ed at the time,	date and pla	ace, and due to	o the cause(s)
	To the I within 2. To tha I complet	Σ	29b. Signature and title of certified				29c. L	icense numb	ber		29d. Date s	igned (Month,	
			anna Pa	til			R	5-0	000	(octobe	112	2005
	1		30. Name and address of person					T. Nage	E. MD	7.75	87-9	in	
	Sta	te.	AHKIT PATEL 31. Date filed (Month, Day, Year)		2. Registrar's S	STREE ignature	1 5637	רוטדו ו ו-	170	414	3 / - 9	100	
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			For State Registrer	of Maryland / Depa	artment of He	ealth and M	ental Hygid	ene 2005	33059
	Physicia /Medic	an	Decedent's Name (First, Middle, Last) Joseph George DePa	scal			2. Date of Death Month 10/11/2	Day Year	3. Time of Death 9:20 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and 7789 Fox Court 5. Social Security Number 6. Sex			ena	8. Date of Birth (Month, Day,)	4c. County of Deat	h
	Director		217-40-1630 186 M 2 F	64	Months Days	Hours Min.	06/28/	1941	MD
10	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hyglene. If itam 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow or other traumatic event, if a Modical Examinational be coefficied at	Funeral Director	1 Never Married 2 Married 1 7 Ye	ecedent Ever in U.S. 13. Forces?				g. Citizen of What Co U · S · A ·	rican Indian,
Maryland 21215-0036	filed within 72 hours at Hygiene. Ather then "naturel", or ent, It's Medical Exam	Completed by	3 Widowed 4 Divorced It Year of Year of Specify only highest grade complete	Give r Dates:		uring most of working	ng S	6b. Kind of Business Social S Administ	ecurity
Aarylan (2 should be f and Mental h le marked of raumatic eve	To Be	Howard Joseph DePa 19a. Informant's Name/Relationship (Type, Print)	19b. Mailie	ng Address (Street a	Gertrud	e Kathe	erine Sc.	Zip Code)
Baltimore, N	mit. Pages 1 and pertment of Heelth cortant: if itam 27 f Injury or other ti		Diane DePascal / W 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	om State 20b. Place of Dispo cemetery, crei	ssition (Name of matory or other place	n Pk 10/	15/05 I	MD 2112 Oc. Location - City or Baltimor Funera	Town, State
	Physician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	at caused the death. Do not ent n each line.	69 Rivie Ter the mode of dying	era Driv , such as cardiac o	e, Pasa r respiratory arres	adena, M	
760,	te be executed was in a particular with the burial-transit and	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of): RHEUMRT to (or as a consequence of):	e Gurti				25 yrs
P.O. Box 68	Physician: The law requires that the deeth certificat this certificete has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Medi	n the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	ρ	Part II. Dther significant conditions contributing t	CRYPTO GEN	16		1 ☐ Yes	acco use contribute to	the cause of death?
Vital Records,	an: The law re tificete has bee tor, page 2 sho	Completed	CHRONIC R	NIN 2° H	YPER 5 LYRE		perform 1 Yes 2	ed? prior to death? ☐ No 1 □ Yes	atopsy findings available completion of cause of 2 No
Division of Vil	ttending death. stor: Afte	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e. Pl	□ Inpatient 2 □ ER/Outpatien title of Injury 28b. Time of Injury	d 28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	ne 5 esiden 28d. Describe how	nce 6 Other (Spe	
Dİ	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certi	29a. Certifier (Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in lanner stated.	h occurred at the time	e, date and place, a	City or Town, and due to the cau ed at the time, dat	use(s) and manner as	s stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier Mylymy			21703	290	d. Date signed (Mont	n, Day, Year)
	Sta Regist		30. Name and address of person who completed of the compl		hoow I lion	Let Suite	1 Pasa	denn, A	10 21122

III C 404		•	for State Registrar	State of Ma	arylan		artment rtificate			nd Men	_	giene Reg. No. 2	005	33060
	Physici /Medic		1. Decedent's Name (First, Middle Elizabeth	Elber	+					Ì	ate of De Month	Day DA	*Pear	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution University of M 5. Social Security Number)	aryland Medic		uten last birthday)	If Under	Hin	nore If Under 24 Hours	Hrs. 8. D	ate of Bir Month, Da	th ly, Year)	9. Birthpl	ace (State or Foreign
P.	Director		none Usual Residence of Decedent 10a. State 10b. County		10c. City	Yrs. y, Town or Lo	ocation		23 2	27 Oc	t 3,	2005	Mary	od. Inside City Limits
	r 28a-f eh	irector	MD How 10e. Street and Number	ard		Ellico	tt Ci					10g. Citizen	of What Coun	1 Nes 2 No
"	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other than "naturel", or Items 23a or 28s-f show or other traumatic event, the Medical Exerting Final Periodifical at	by Funeral Director	2979 Brookwood 11. Marital Status 1 ☑ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces?			_		panic Origir , Mexican, I	042 n? (Specify Puerto Ricar	Yes or No)- 14.	USA Race - America Black, White, e	etc.
21215-0036	in 72 hours a "naturei", o Isolgal Exer	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highes	If Yes, Give Year or Dates: s Education t grade completed)		16a. Dece	dent's Usua kind of wor.	l Occupat k done du	Specify:	of working			ecify: Whi	ite Justry
nd 212	oe filed within all Hygiene. d other then "	Be Com	none 17. Father's Name (First, Middle, 1	College (1-4or 5 none .ast)	·+)	none			18. Mother's	s Name (Fir	st, Middle,	none Maiden Sui	mame)	
Maryland	nd 2 should be ith and Mental 27 ie marked o	2	Alexande: 19a. Informant's Name/Relationsl University of	ip (Type, Print)					nd Number		ite Numb		own, State, Zip 21201	Code)
Baltimore,	permit. Pages 1 an Department of Heal importent: if item 2 eny injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from State	C	tace of Dispo	osition (Nam	ne of	1	Date			ion - City or To	wn, State
Balt	permit. Departr importe eny inje		21. Lignature of Funeral Services Conald Con	Wade, Dir	ector								imore S	treet Approximate
	Physician /Medical Examiner property of the printing fund the printing of the	Examiner	shock or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list and tons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as c. Due to (or as	LUCA a consequence a consequence	uence of): Lo IDE uence of):	rax	nei ret	inu	m				Interval Between Onset and Death
.O. Box 68760,	death certific e ettending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregna	Ideath 3	Ectopic pre		Tur	174		23d.	Date of deliver	ry Day Year
Δ.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ns contributing to death b	ul not resi	ulling in the u	inderlying ca	ause giver	n in Part I.		23e. Did t	/		e cause of death? ably 4 Unknown
al Records,	The ste h page	Completed								_	24a. Was autop perfo I ☐ Yes	osy ormed?	prior to con death?	esy findings available inpletion of cause of
Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospitat:				Other	-	f Death (Ch				
ō	ing After	atlon: To	1 Yes 22 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Inju (Month, Da		28b. Time o Injury		Bc. Injury Work	4 Nurs	28d.		dence 6	Other (Specify)
Division	ne Hospital or Attendi 24 hours after death ne Funerel Director: A pletely filled in by the th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place of Inj building, et	c. (Specify	y)					City or To	wn, State)		Route Number,
	출 등 출 분	Medical	(Check only 2 Medicat one)	g Physician: To the best Exeminer: On the basis o and manner st	examina	wledge, deat tion and/or in	vestigation,	in my opi	nion, death	place, and d occurred at	the time,	date and pla	ce, and due to	the cause(s)
	Mill To		29b. Signature and title of certified	Vonde	M	D -		D D	061	0.78		D-C	gned (Month, D	DD5
			30. Name and address of person 22 S. Greene	Street, Roon	AN	3W68	Perlt	Ada	ora l	Wond	di	2120	1	
3.	Sta Regista		31. Date filed (Month, Day, Year) OCT .1 3	2005 Electric	ar's Signa	ture	de		,					

CPM 05-06785 Michael Fleming

		•	For State Registrar		State o	of Mar	yland / Dep <i>Ce</i>	artmen rtificat			nd Me		iene	005	33061
	Bi vivi		1. Decedent's Name (First,	Middle, La	st)		-				2	2. Date of Deat Month	th Day	Year	3. Time of Death
	Physicia /Medic		MICHAEL 1	G. F	LEMINO	Э <u> </u>						October		2005	14:57 M
	Examin		4a. Facility Name (If not ins	titution, giv	e street and nu	ımber)		4b. City,	Town, or l	_ocation of I	Death		4c. Co	unty of Death	
			rear of 2624	Har1				1		imore				NA	
	Funeral Director		5. Social Security Number		Sex 1.DMM 2.□F		n yrs. last birthday Yrs.	Months		If Under 24 Hours	Min.	3. Date of Birth (Month, Day,)2 ·07 ·	1972	9. Birth	place (State or Foreign htry)
	pud a	1	Usual Residence of Deced	County		1	Oc. City, Town or I	ocation						T	10d. Inside City Limits
	sho sho	5	dW	N	Δ		BALTIMOR								1 ✓ Yes 2 ☐ No
	1he A	ect	10e, Street and Number	1			SHEITHOR	10f. Zig	Code			1	On Citizen	of What Cou	nta/2
	with sor	Funeral Director		τη Δ	VENUE			101. 21	2121) .			og. Omzor	USA	y.
	ne 23	era	11. Marital Status	.1V(F\	12. Was Dec	edent Eve	er in U.S. 13	. Was Dece			n? (Spec	fy Yes or No-	14.	Race - Ameri	can Indian,
	Iter d	표	1 Never Married 2	Married	Armed F	orces? 2 No		If Yes, spe	cify Cuban	, Mexican, I				Black, White,	
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Di	vorced	If Yes, G Year or I			1 🗆 Yes	2 ☑ No	Specify:			Sp	ecity: BU	ACK
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "naturel", or Iteme 23a or 28a-f show event, I're Medical Examinar must be mailled at	Completed		ecedent's E	ducation ade completed)		edent's Usu		tion uring most o	of working		16b. Kind	of Business/In	dustry
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Maryland		Be	17. Father's Name (First, I LEROY FLEN		"					Juua Juua		First, Middle, I RAHAM		mame)	
Ž	s 1 end 2 should I Health and Men Item 27 le marke other traumatic	2	19a, Informant's Name/Re		(Tyne Print)		19h Mai	ling Address				Route Number		nwn State Zii	Codel
S	nd 2 shoulth and 27 le m			MING		HFR	1	CLAY		_		BAITO.	MD	21211	•
	: 1 end Health tem 27 other ti		20a. Method of Disposition		-		20b. Place of Disp	osition (Na	me of		Da,	-		tion - City or T	
J0			1 ☐ Burial 2 ☑ Cren 4 ☐ Donation 5 ☐ C			State	cemetery, cr GREENN	•		. 1	. 14.	.05	3A1TI	MORE	100
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			23a. Part1. Enter the dise shock, or heart failu	ase, or con	plications that	caused th									Approximate Interval Between
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	and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	1	c.	lor as a	consequence of):				_				
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387		dicai			d										
_	eath certifii attanding p	N/S	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, or								230	f. Date of deliv	erv
Вох	death certif le attanding le for use a	Physician/Me	in the past 12 month 1 ☐ Yes 2 ☐ No					☐Ectopic p ☐ Other (s)						Month	Day Year
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	The law requires that the ste hes been signed by th bage 2 should be detache	by P	Part II. Other significant	conditions	contributing to	death but	not resulting in the	underlying o	cause give	n in Part I.		23e. Did to	bacco use	contribute to	he cause of death?
ğ	quire en sig											1 □ Y	es 2 🗆 N	No 3□Pro	bably 4 Unknown
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Vital Records,	The I	Completed									_	autops perfor		death?	empletion of cause of
ita	sician: Th certificete rector, pag	Bec	25. Was case referred to examiner?	medical						26. Place o	of Death	(Check only or			
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		on:	27. Manner of Death 1 Natural 5	Pending		e of Injury onth, Day o			28c. Injury Work	at ?		8d. Describe h			
Sio	eat or:	cat	2 Accident 3 Suicide 6	Investigation	ho	-5 - c		15 M		es 2 No		UNK			
Division	or Attendate death Director: in by the	Certification:	4 Homicide	determine	200. Fial	ding, etc.	- At home, farm, (Specify)	street, factor	y, office		1	City or Tow		34 H	al Route Number,
	spital ours a		29a. Certifier 1 ☐ C	ertifying P	hvsician: To the	ne best of	my knowledge, de	Sth occurred	t at the time	e date and	place, ar	nd due to the c	Mercels) an	nd manner as	stated
	To the Hospital or Attenwithin 24 hours after deat You the Funerel Director: completely filled in by the	Medical		ledical Ext	miner: On the	basis of e	xamination and/or	investigation	n, in my op	inion, death	occurre	d at the time, o	late and pla	ace, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of	certifier	^		<u> </u>	29	c. License	number		2	29d. Date s	signed (Month,	Day, Year)
			Poto.	. : (hom	11-	Kall L			O.C.M	1.E.		0cto	ber 06	, 2005
1	1		39-Name and address of	person who	o completed car	use of dea	th (Item 23a) (Typ								
7	1		TATRICIS	Aron	ica-to	Mak	MD 11	Penn	Stre	eet, E	Balti	more,	Mary1	and 21:	201
	Sta Regist		31. Date filed (Month, Da	1 3 20	05	Registrar*	s Signature	ode							
	TEGISI	4.1			7	A COL	- //								

Amend item#29c, perDVR, C848, 10/13/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33062 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FIEIDS Month Day OCTOBER 10 Physician VANESSA 4:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HUSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 AF Months Hours 5/ 622972 10 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Itema 23s or 28s-f show the Medical Exemprer must be notified at BAITIMORE 1 Yes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 521 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACH þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CARE PIOVIDER and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FIELDS EARI LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BAlto MB of Health a AVE ANthony 5219 Williams Pages 1 and 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ita
eny injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-05 BALTO, MO. MEMORIAL PIXX 4 □ Donation 5 □ Other (Specify) KINGS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2431 E. OI.VER Phillip A Weatherton Phillip A. WEAtheltoRo BALLO MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner SEVERE PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner ASPIRATION PNEU MONIA P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Salim Baghhi October 10th - 2005 P18801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLUD SALIM BAGHLI . MD GOOD SAMARITAN HOSPITAL BALTIMORE-MD - 21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Car Year)

3 2005

			For State Registrar		State of	Maryland /	-	artmen rtificate				-	giene Reg. No	201	J 5	330	163
			1. Decedent's Name (Fir	st, Middle, La	ist)							2. Date of De Month			V	3. Time of	
	Physici /Medio		Cather	ine			F	reema	n			DCT	Day		Year	8:00	AM
	Examir		4a. Facility Name (If not	institution, giv	e street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. C	ounty o	f Death		
			1413 E. L		te Avenu	е				timor				NA			
	Funeral		5. Social Security Number		Sex 7. 1□M 2127F	Age (In yrs. last		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	h y, Year)		9. Birthpla	ace (State of	r Foreign
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	and w			. County		10c. City, To	own or Lo	cation							10	d. Inside Cit	v Limits
	Maryl f sho	ō	Md.	N.	IA		Ba	ltimo	re							XX Yes	2 🗆 No
	the 28a-	rec	10e. Street and Number	-				10f. Zip					10g. Citize	en of W	hat Count		
	with 3a or	<u> </u>	1413 E.	Lafave	tte Aven	110			1213					SA		,	
	death ms 2	Funeral Director	11. Marital Status	-a-a ₁ c	12. Was Decede	ent Ever in U.S.	13.				gin? (Spe	ecify Yes or No Rican, etc.)		Race	- America		
9	after or ite	교	1 Never Married	2 Married	Armed Force		1	_				Rican, etc.)			, White, e		
5-0036	72 hours after death with the Maryland natural', or Hems 23a or 28a-1 show licel Examinat must be notified at	l by	3	Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2	NO LYS	Specify:			5	pecify:	Blac	k	
5-0	72 h	Completed	15. (Specify or	Decedent's E	ducation ade completed)	16	Sa. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation furing mos	t of work	ina	16b. Kin	of Bus	iness/Ind	ustry	
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21	filed withii Hygiene. other than ent, Ithe M	S	3rd grade 17. Father's Name (First,	Affection 1 and	1)		DOIL	estic		40.11.11		(200) - 1.41.4.4				e Home	es
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Ma	12 sho h and 7 is mu traum		19a, Informant's Name/F					_				al Route Numbe					
	1 and 2 Health tem 27		Tracha Joh 20a. Method of Disposition		N.			ட். ப		ette		nue, Bal			Md. City or Tow	21213	3
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		`4 Donation 5 □			Gar	1	n For				.8–05	Owin	gs N	Mills	, Md.	
Bal	permi Depar Impo any ir		21. Signature of Fune	Milian	nsee			. Name and				Baltimo				2	
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				ure. List only	one cause on eac	h line.	o not en	er the mode	e or ayıng	g, such as	cardiac o	or respiratory ai	rest,			Approximate Interval Betw Onset and D	reen
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7	ted nsit	n lu	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury)	4	A	tr 11.		·C							-10	8	0 65
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	- 1	c. Due to (or	as a consequenc	e of):	(7)		 						7	C1117
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Box	The law requires that the death certific ate has been signed by the attending pl bage 2 should be detached for use as t	N/S	IF FEMALE: 23b. Was decedent pred	inant	23c. If yes, outco								23	d. Date	of deliver	,	
ğ	that the death led by the atter detached for u	clai	in the past 10 mont		4□Pregnan	n 2 ☐ Fetal dea It at time of death]Ectopic pre] Other (spe						Mont			ear
P.0.	the cy the achee	hysi	9 Unknown		9□ Unknow	n						,Cest sa					
	signed to		Part II. Other significant	conditions	contributing to deat	h but not resulting	g in the u	nderlying ca	luse give	n in Part I.		23e. Did to	bacco use	contrit	oute to the	cause of de	ath?
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Division of Vital Records,	law requir as been si 2 should I	Completed by	DIAL	2 te	ک							24a. Was	an	24b. W	ere autop:	sy findings a	vailable
Re	ician: The lar certificate has ector, page 2	шо											med?	pri de	ath?	pletion of ca	use of
tal		BeC	25. Was case referred to	medical						26 Place	of Death	1 ☐ Yes	2XINo	1 (Yes 2	No	
>	ysici is cer direc	To B	examiner?		Hospital: 1 Inp	atient 2 ER/0	Outpatier	t 3□ DO	A Othe			ne 5 Resid		Other	(Specify)		
10	ding Ph n. After thi funeral	n: I	27. Manner of Wath		28a. Date of (Month,	njury 28b	. Time o	28	Bc. Injury Work			28d. Zescribe h					
Ö	ath. r: Aft	atlo	2 ☐ Accident	☐ Pending investigation	n	Day (dai)	inquiry	М		es 2 🗆 !	Vo						
Vis	l or Attendi after death. Director: A I in by the fu	if	3 Suicide 6 [Could not be determined	280. Place of	Injury - At home, , etc. (Specify)	farm, str	eet, factory,	, office		1	28f. Location (S City or Tow	treet and	Number	or Rural	Route Numb	er,
Ö	tal or s afte al Diu	Certification:			Dallaling	, dia. (Spoony)						Oily or Ton	n, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical	29a. Certifier (Check only	Certifying P	hysician: To the be miner: On the basi	est of my knowled	ge, deat	occurred a	at the tim	e, date and	d place, a	and due to the	ause(s) a	nd mani	ner as sta	ted.	
	the H in 24 the F iplete	ledi	one)		and manner	stated.	and/or in	vestigation,	штиу ор		in occurr	eu at the time, t	Jate and p	iace, an	id due to t	ne cause(s)	
	To To	Σ	29b. Signature and title	of certifier	277	111	A 50		License				29d. Date				- Carrier
•			man	re	muc	00	9		NY	575	> 7	15	DC	7 1	110	-00	7
	5		30. Name and address o	f person who	completed cause	of death (Item 23a	a) (Type,	Print)		~		Ave	0			513	124
	5		Matth	- R W	(MCNGS	ney	43	SF.	٤٥	: 746	YN	Ave	<u> R</u>	513	F M	(3)	
27	Sta	- 75	31. Date filed (Month, Da	y, Year) T 1 3 2		istrar's Signature	A	adi)									
10	Registi 	ar	UU	1 1 9 4	LUUJ FA	The state of the s	-/										

Catherine Freemen

			1 - For State Registrar	State of Marylan		artment of H			jiene eg. No 2005	33064
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		G	tross.		2. Date of Dea Month		3. Time of Death
	Examin		4a. Facility Name (If not institution, give st 2555 ARUNAH AN	treet and number) VENUE		BALTIMO				ath A
	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 2 F 7. Age (In yrs. Q2)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. E	irthplace (State or Foreign Country) MD
	Maryland -f show	tor	10a. State 10b. County MD NA		y, Town or Lo					10d. Inside City Limits 1 No 2 No
	with the	ii Direc	10e. Street and Number 2555 ARUNAH AVE	ENUE		10f. Zip Code	,	1	0g. Citizen of What	
920	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "naturel", or items 23e or 28e-f show event, the Medical Exacting must be notified at	by Funera		2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 L.No If Yes, Give Year or Dates:	ĺ		lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
215-0	within 72 ho ene. then "natur he Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of work	ing	16b. Kind of Busines	ss/Industry
Maryland 21215-0036	id be filled within ental Hygiene. ked other then '	To Be Cor	9 TH GRADE 17. Father's Name (First, Middle, Last) WILLIAM FOWLER	NA	Cusio	DAID	18. Mother's Name		GOVERNM Maiden Sumame)	:V11
Mary	s 1 and 2 should be f Health and Menta item 27 Is marked other treumatic ev	-	19a. Informant's Name/Relationship (Typ	08, Print) VIECE)				al Route Numbe	r, City or Town, State	, Zip Code)
	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. F	lace of Dispo	sition (Name of matory or other place		Date	20c. Location - City	
Baltimore,	permit. Pages Department of Importent: If i any injury or once		21. Signature of Funeral Service License		VP	Name and Addre	ss of Facility REENE FU IATU PIKE	NERAL SE	BALTO. MO ERVICE IN 21229	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. July 5 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	h. Do not ent	er the mode of dyin		or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to a large leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
.O. Box 6	at the death certific by the attending p tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Date of o Month	delivery Day Year
<u>α</u>	es tha	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Onknown
Vital Records,	0 5 0	ompieted	diastoli	2 dysfo	ncti	oosuve	,	24a. Was a autop: perfor	sy prior t med? death	
Vital	Physician: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	lospital:	- 20	Oth	26. Place of Deat	h (Check only or		
of	ding h. After fune	ation: To	1 Yes 2 No 27. Manner of Death 1 Tratural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injur	4 Nulsing No	-	ence 6 □Other (S) ow injury occurred	oecify)
Division	tel or Attendi rs after death. el Director: A ed in by the fu	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edicai		sician: To the best of my knowner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	Jenlus	w	29c. Licens			9d. Date signed (Mo	
(0 -		30. Name and address of person who col	mpleted cause of death (Iter	n 23a) (Type,	Print) Novtha	& PKINL	Suitel	OI Balt	05- 014 21210
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 3 2005	/32. Registrar's Signa	ature	w	1	1,		

UNK	Please Type or Print in Black II State of Maryland / Der		
05-06826 RJ	1- For Unpend Item 23a,27,28a-r per mer Registrar	G848 10-14-05 tas entificate of Death	Reg. N2005 33065
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of De. Month	ath Day Year 3. Time of Death
/Medical	William Karl Groleau 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	r 6, 2005 10:59 p.
Examiner	217 Westowne Road	Baltimore	Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 11XM 2 F 50 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Bin (Month, Days Hours Min. Sept 30	th, Year) 9. Birthplace (State or Foreign Country) Mary Land
Director	Usual Residence of Decedent		
ehow	10a. State 10b. County 10c. City, Town or Maryland Baltimore	Catonsville	10d. Inside City Limits 1 ☐ Yes 2 🖔 No
vith the Ma	Maryland Baltimore (10f. Zip Code	10g. Citizen of What Country?
bre, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene item 27 is marked other than "natural; or items 23s or 28s-1 show other traumatic event, the Medical Expriner must be notified at The Po Commissed by Eumeral Director	1304 Hilton Terrace	21228	USA
Iter death v	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married	 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	14. Race - American Indian, Black, White, etc.
036 burs aff	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
21215-00 ed within 72 ho ygjene. Per then "natur. 11, ILM Medical.	15. Decedent's Education (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working a. DO NOT use retired)	16b. Kind of Business/Industry
212' d withir piene.	Elementary/Secondary (0-12) College (1-4or 5+)	ccountant	Self Employed
nd 2	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle)	
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hyglene. If item 27 is marked other than "natural", or any injury or other traumatic event, it a Medical Examples.	George E. Groleau 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Mary L. Z	and the second s
Ma ind 2 s alth an 27 is or trau	1121	Hilton Terrace Catonsvil	
Pages 1 and to the the the the total to the	1 Burial 2X Cremation 3 Bemoval from State	sposition (Name of Date rematory or other place)	20c. Location - City or Town, State
Baltimor permit. Pages Department of Important: If it any injury or o	4 Donation 5 Other (Specify) Metro Cr	rematory Inc. 10/10/05	Baltimore, Maryland
Balt permit. Departiment		Cremation Society Of Mary 299 Frederick Road Baltim	land Inc. ore, Maryland 21228
	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot	Wound To Chest	
Examiner	Due to (or as a consequence of):		
pe is	Sequentially list conditions, if any, leading to influence to cause. Enter Underlying Cause (Disease or injury		
60, be executed sicien and burial-transit	that initiated events c. — Due to (or as a consequence of):		
D 20 10 10 10 10 10 10 10 10 10 10 10 10 10			
Division of Vital Records, P.O. Box 6876 or attending Physician: The taw requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the but	IF FEMALE: 23c, If yes, outcome of pregnancy		23d. Date of delivery
Geath death	23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
P.O nat the d by the letache	9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I 23e. Did	tobacco use contribute to the cause of death?
cords, P wrequires that s been signed t should be det	Tarin. Butto organization	, , ,	Yes 2 No 3 Probably 4 Unknown
Il Record The taw requir cate has been si		24a. Was	prior to completion of cause of
I Rec		perfe 1 Yes	ormed? death?
Vita sicien sicien certificactor.	25. Was case referred to medical	26. Place of Death (Check only	one) Idence 6 Dother (Specify) At scene
ig Phy ter this		e of 28c. Injury at 28d. Describe	how injury occurred
Vision Attending r death. ector: Atten	2 Accident investigation 3 Asuicide 6 Could not be	7 P ^M ^{1 Yes 2} X ^{No} Subject	Shot Self
Divi	27. Manner of Death 1 Natural 2 Natural 3 Xisuicide 4 Homicide 2 Natural 3 Xisuicide 4 Homicide 3 Natural 5 Pending investigation 6 Could not be determined 6 See. Place of Injury - At home, farm, building, etc. (Specify) Scene		(Street and Number of Rural Route Number, Nan, State) 217 Westowne Road ore County, Md
		eath occurred at the time, date and place, and due to the	cause(s) and manner as stated.
To the H within 24 To the F complete	29a. Certifier Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Physician: To the bast of my knowledge, d (Check only one) Certifying Ph	29c. License number	29d. Date signed (Month, Day, Year)
F 3 F 3	I Jasha & Treat dep	OCME	October 7, 2005
	30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 111 Penn Street Bal	timore, Maryland 21201
Stat	31. Date filed (Month, Day, Year) 32. Registrar's gignature		
Registra		& Aparle	

	1	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of H <i>tificate of L</i>	ealth and I D <i>eath</i>	Mental Hygi Re	ene20	05	33066
Physicia	n	i. Decedent's Name <i>(First, Middle, Last)</i> Kenneth Jo	seph Gaeng				2. Date of Death October		005 ^{Year}	3. Time of Death 7:20 P M
/Medica Examine		la. Facility Name (If not institution, give st Brightview	reet and number)		4b. City, Town, or White Ma		h		y of Death	ore
Funeral Director		212 20 3107	7. Age (<i>In yr</i> s. <i>Ia</i> 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Ĭ923	9. Birthi Coul Mar	place (State or Foreignty) Yland
Maryland a-f ehow		Usual Residence of Decedent 10a. State 10b. County Md. Baltimor		.Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🖔 No
h with the	ਙ∣	10e. Street and Number 8100 Rossville	Blvd.		10f. Zip Code 21236		10	0g. Citizen of		ntry? ISA
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Example must be multilled at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Bla	ce - Ameri ack, White, ify:Whit	etc.
within 72 hou ene. then "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	tent's Usual Occupa kind of work done of DO NOT use retired YEN	luring most of wo	rking	Law	Business/Ir	ndustry
uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Francis Gaeng				Eleand		ser		
and 2 sho alth and 1 27 is ma or trauma		19a. Informant's Name/Relationship (Type Ir. Thomas Gaeng/ So	on	5105	Greenhil		Baltimor	e, Md.	2120)6
Pages 1 iment of He ant: if item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Ce	emetery, crer kwood	sition (Name of natory or other plac Cemetery	10-8	3-05	20c. Location Parkv	-	
Departi Departi Import eny inj		21. Signature of Funeral Service License	1		Name and Address 1050	York Ra.	uneral Ho Towson,		204	Approximate
the death certificate be executed /Medical Examination and cheef for use as the burial-transit	Ilcal Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	grosto	TW DE	EUNN 	9		Internal Between
that the death certific ed by the attending p detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnated to the second of the sec	death 3	Ectopic pregnancy Other (specify)				ate of deliv	rery Day Year
that ed b deta	leted by Ph	Part II. Other significant conditions con	stributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	_	ntribute to	the cause of death? bably 4 ∏Unkno
The lar	Comp						120/2016 120/20	ned?	. Were autoprior to condeath?	opsy findings availa ompletion of cause of
iding Physici th. : After this cer funeral direc	tlon: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Statural 5 Pending 2 Accepted investigation	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗆 Nursing l	Home 5 Reside	ence 6 □0		ify)
ital or Attandi urs after death. rs! Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify				City or Town	n, State)		ral Route Number,
To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one) 29b. Signature and title of gertifier	sician: To the best of my kno ner: On the basis of examina and manner stated.	wieage, deat tion and/or in	h occurred at the tirvestigation, in my o	pinion, death occ	urred at the time, d	ause(s) and riate and place	and due	to the cause(s)
(X)		30. Nagle and address of person who	my hed cause of death (Item	n 23a) (Type.	Print //)-	Dec	7-20	0/0		2120

DHMH 17 Rev 1/2001

Registrar

2005

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ORIGINAL

05-4208 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKNOWN State of Maryland / Department of Health d Mental Hygiene Griffin, Gilbert - For State Registrar Reg. Ne. 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 20 JUNE 2005 1423 P GILBERT GRIFFIN /Medical 4a. Facility Name (If not institution, give s 1125 RIGGS AVENUE 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Yrs 53 Director 215-60-1172 JULY 31 1952 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 XYes 2 No Director MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö or items 23a 755 GRANTLEY STREET 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Exactiner Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiens Important: If Item 27 ie marked other that any injury or other traumatic event, Item 2006. GED CONSTRUCTION TILE SEWING CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALBERT LEE GRIFFIN HELEN IRENE PEEBLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Griffin/Sister 755 N. Grantley St., Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 1.4 □Donation 5 □ Other (Specify) METRO CREMATORY 10-13-05 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part). Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death olications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) cause Pnysician anatomic 0+ NO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): ettending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 0.0 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ∭ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours eiter death.

To the Funerel Director: After this certified completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE Hospital: 2 1√2 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 XNo unkown unknown unknown 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Found in a vaeant house 1125 Riggs Ave Paltimore mid 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME JUNE 21, 2005 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street LING LI MID Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 1 State 2005 case A SERVE Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

			1 - For State Registrar	Oldio of Mic	Ce	ertificate of	Death		ig. No.	33069		
*	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat	Day Year	3. Time of Death		
a.	/Medic	al		RGINIA LEE	GONZALEZ			October	8,2005	16:30 M		
50	Examin	er	4a. Facility Name (If not institution, giv				or Location of Deal	th	4c. County of Dea	th		
R	Funeral	W	SEASON'S HOSPIC 5. Social Security Number 6.8		(In yrs. last birthda	ELKT	If Under 24 Hrs	8. Date of Birth	CECIL	9. Birthplace (State or Foreign Country)		
\$. ₀	Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (S									
	Aaryland f ehow	ō	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2X No		
	the N	Director	MARYLAND CECI 10e. Street and Number	L CO	EL	10f. Zip Code		10	Og. Citizen of What Co			
	3a or		69 WINDCHESTER	סח		219	2.1					
	deati	ner	11. Marital Status	12. Was Decedent 8	ever in U.S. 13	. Was Decedent of H		pecify Yes or No-	U.S.A. 14. Race - Ame			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 le marked other than "natural", or iteme 23e or 28e-f show other treumatic event, the Macical Examiner marable modified at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo	1 Yes 2 No	an, mexican, Puer Specity:	to Hican, etc.)	Specify: B	e, etc. LACK		
5-0	72 ho natur	eted	15. Decedent's E		16a. Dec	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of Business	/Industry		
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	filed w Hygie other t	S	12th grade	2 yrs NURSING (LPN)					HEALTH			
Maryland	d be f	Be		,				me (First, Middle, M	valuen Surname)			
2	should be ind Mental marked o	2	JOSEPH WEBSTER 19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street	MARI		City of Town State	ity or Town, State, Zip Code)		
S	and 2 saith ar n 27 le		Conjetta Ferebee						vland 219	·		
ē,	s 1 and Heal		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla			Oc. Location - City or			
E	Page nent o int: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ROLLING O			13-05	W CHESTER	DΛ		
Baltimore,	permit. Pages 1 and Depertment of Heall Importent: If Item 2 eny Injury or other Once.		21. Signature of Funeral Service Licer	1seg /	V	22. Name and Addre	ss of Facility I COMM FU	NERAL HOM	E-HARFORD	. P.A.		
	Physician /Medical		321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat disease or condition a. Lung Cancar The mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Such Cancar The mode of dying and the cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Such Cancar The mode of dying and the cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Such Cancar The mode of dying and the cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Such Cancar The mode of dying and the cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Such Cancar The mode of dying and Deat Such Cancar									
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5	Examiner		Sequentially list conditions,	b								
	ad sit	lnei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):							
	rificate be executed by physicien and as the burial-transit	Examiner	resulting in death) Last Due to (or as a consequence of):									
68760,	sicien buria	alE	l l									
687	ificate p physical ph	Medical		d								
	n cert	IN/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of del	ivery		
P.O. Box	res that the death cei igned by the ettendii be detached for use	Physiclan/	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	the past 12 months? Yes 2 No 4 Pregnant at time of death 5 Other (specify)								
	hat th ed by detach		Part II. Dther significant conditions of	ontobuting to death by	t not resulting in the	underhing course an	on in Dart I	23a Did tob				
ds,	signe d be	d by			use contribute to the cause of death? 2 No 3 Probably 4 Unknown							
Sor	w require been sig should t	ete										
al Re	Attending Physician: The law requires that the death certificate be executed crossin. crossin. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed		ed? prior to death?								
Ž	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 3 DOA Oth	er	ath (Check only one		Corint duratte:		
Division of Vital Records,	Physic this aral di	. To	1 ☐ Yes 2 🔼 No 27. Manner of Death	1 🔲 Inpatiei		III JUDON	4 🗆 Nursing F	lome 5 Resider 28d. Describe how	nce 6 Other (Spec	have		
	ith. : After s funer	tlor	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined elemined. 28. Place of Injury. At home, farm, street, factory, office 281. Location (Street)							et and Number or Rural Route Number,		
Vis	Atternation description	Certification;										
٥	itel or irs afte rel Din led in l	Cer						City or Town,				
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or is	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the car irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)		
	To the within To the comple	Ž	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month			
	1		> It fork	ワーハロ		115	314	Oc	toher 10 wo	5		
(1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print)		do	toher 10, wo			
)		31. Date filed (Month, Day, Year)		r's Signature	sapethe 1/0	spice El	Klan, MP				
	Sta Registr		OCT 1 3 21	195 January	a signature	Land.						

			For State Registrar	State of M	larylar	nd / Depa	artmer	t of H	ealth a	ind Me	He	iene 0	05	33070
	Physicia		Decedent's Name (First, Middle, PAUL	Last)			GO	LDBE	RG	1	2. Date of Death Month OCTOBE	Dav	Year 2005	3. Time of Death 1:05 P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	r)				Location of			4c. County		
			SINAI H	USPITAL			13	ALTI	MORE	;				N/A
	Funeral Director		213-03-4003	. Sex 7. A 1 M 2 □ F	ge (In yrs. 88	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs.	8. Date of Birth 07/02/9/44	717	9. Birthp Coun	lace (State or Foreign try) MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						1-	0d. Inside City Limits
	the Mary 28a-f sho	ector	MD N/	A	В	ALTIMO		Code				og. Citizen of V		1 X Yes 2 □ No
	Mith Ba or	Ö	7111 PARK HEIG	HTS AVENUE	ΔΡΤ	. #712		21215				-	S.A.	uyr
	death ms 2;	era	11. Marital Status	12. Was Deceden	t Ever in U					gin? (Spec	cify Yes or No-	14. Rac	e - Americ	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, if a Medical Exemple of neat be notified at	Completed by Funeral Director	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 X Yes 2 If Yes, Give Year or Dates] No		fYes, spe 1 □ Yes		n, Mexican, Specify:	, Puerto F	lican, etc.)	Specify	ck, White, W	HITE
5-0	72 ho	etec	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usu kind of wo	al Occupa	ation during most	of workin	a ·	16b. Kind of B	usiness/Inc	lustry
121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or	r 5+)	OWN		se retired)			FI FCTRI	ΓΔ1 Ι	CONTRACTOR
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اسهم Paul Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked o any Injury or other traumatic ave ones.	To Be	HARRY 19a, Informant's Name/Relationship	Α			OLDBE		ROSE				1	WEINER
Mal	d 2 st th and th and traun		NATHAN GOLDBERG								Route Number, BALTIMO			
نام درور imore, Ma	tem 2		20a. Method of Disposition	/ BROTHER	20b.	Place of Dispo						20c. Location -		
10 E	Pages nent of int: if it iry or o		1 X Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		8					0/12	/2005	RANDALI	STOW	N. MD
# ⊕	permit. Departm Importa any Inju		21. Signature of Funeral Service Li		DE						LEVINS			
Ω	89 5 8 8	. 11	Michaus	Druge	~	89	00 RE	CISTE	RSTOW	IN RO	AD - PII	KESVILI		
	Physician /Medical Examiner pnuisi-itausi	Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a conse	ARTERY quence of):	_							Interval Between Onset and Death
P.O. Box 68760,	ath certificate ttending physior use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fet	al death 3	Ectopic p					1.	te of delive	ry Day Year
ď.	res that the de signed by the a be detached t	by Ph	Part II. Other significant condition		_		nderlying o	cause give	en in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
ord	w require been sis	ted	CONGESTIVE	HUR7 1	FAILU	RE					1 ☐ Ye	s 2 No	3 Prob	ably 4 ∐Unknown
Division of Vital Records,	sicien: The law r certificate has be irector, page 2 sh	Completed	AUNTIC STE	NOSIS	-						24a. Was ar autopsy perform 1 Yes 2	ned?	prior to cor death?	osy findings available inpletion of cause of 2 No
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of \	Physic this c	ို	1 Yes 2 No			ER/Outpatier		OA Othe	er: 4 🗆 Nur		e 5 ☐ Reside)
sion (utending F death. ctor: After y the funera	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t bo		28b. Time o	М		rat ⟨? Yes 2□N	No	8d. Describe ho			
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	4 Homicide determin	ed 286. Place of I	etc. (Speci	ify)					City or Town	, State)		Route Number,
	e Hospital 124 hours a te Funeral l	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best kaminer: On the basis and manners	of examin	owledge, deatl ation and/or in	n occurred vestigation	at the time, in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	inner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					c. License				d. Date signe	d (Month, I	Day, Year)
			JOHN KEC	HII NWAN	IKWC	, M.	D	RES	00	0	(CTOBE	RI	, 2005
	12		30. Name and address of person w	ho completed cause of 2401 v	death (Ite	m 23a) (Type,	Print)							21215
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	ature	W		· · · · · ·					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Curtis Aiden Gough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE BALTIMORECITY GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea 6/7/1951 9. Birthplace (State or Foreign Funeral 1X M 2 ☐ F 217-54-8387 Maryland 54 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar mast be notified at MDPerry Hall Director Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 4204 Hollow Spring Lane 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Funeral Mortician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Item 27 is marked ott Mary F. Petersam John E. Gough Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Diane S. Gough/Wife 4204 Hollow Spring Lane Perry Hall, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 10/10/05 Baltimore, Maryland Gardens of Faith ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 1 23a. Part1. Enter the disease, shock, or heart failure. operications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS Physician /Medical Due to (or as a consequence of): Examiner PNEUMONYA Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to (or as a consequence of Examiner sician and burial-transit Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the 9☐ Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kin toned Disease on 1 🗌 Yes 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has To the Hospital or Attending Physiclan: The within 24 hours alter death.
To the Funeral Director: After this certificate tompletely filled in by the funeral director, page Stroke PENO 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D RES DOD 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) KHANNA GODD SAW ARITAN State Registrar

			1- For Amend Item :	State of Maryla 23a per Dr.,	6848, Le	ving tifica	nt of Head 05dlpb te of De	alth and	Mental Hy	giene	005	33072	
	Physic		1. Decedent's Name (First, Middle, Last) Rose Hill 2. Date of Death Month Day Year OCT 11 2005 15:23 M										
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltmore Baltmore									ath	
委	Funeral Director		5. Social Security Number 6. Security Number 214-03-2542	7. Age (In yr.	s. last birthday) Yrs.	If Und Months		f Under 24 Hrs Hours Min.		th ly, Year)	9. Bi	rthplace (State or Foreign ountry) ryland	
	Maryland	tor	10a. State 10b. County MD n/a		City, Town or Lo							10d. Inside City Limits 1	
	with the 3s or 28s	Funeral Director	10e. Street and Number 3206 O'Donnell	Street		10f. Z	ip Code 21224				zen of What C	country?	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumatic event, the Madical Examinar must be notified at ORCs.	by	11. Marital Slatus 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Yes 2 No Specify:				No- 14. Race - American Indian, Black, White, etc. Specify: White				
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Maryland		To Be	17. Father's Name (First, Middle, Last) Frederick Fried					Sara	ne (First, Middle ∩ I . K∈	tch	um		
-			19a. Informant's Name/Relationship (Ty Matthew L. Hill 20a. Method of Disposition			0'	Donne		Balti Date	mor		21224	
Baltimore			1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State	cemetery, cien aklawn	natory`or L	other place)		14/2005	Ba	ltimor	ce, MD	
Ba	permit. Departr Importu any inji		Maria H.	Zannere	20	5 5	· COII	KIIIIG	St. Ba	TCI	annino Jr. FH nore,MD 21224		
	Physician		23a. Part1. Enter the disease, or comptishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	A	,			-	or respiratory a			Approximate Interval Between Onset and Death	
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60,		i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
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of Vital Records	ding Physician: n. After this certifica tuneral director, p	e Completed	25. Was case referred to medical	1 ☐ Yes						rmed? 200 No	prior to completion of cause of death? No 1 Yes 2 No		
of V		To B	1 1 185 282140		ER/Outpatient		OA Other:		ome 5 Resid	dence 6		icify)	
Division		Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury al Work? M 1 Yes 2 No				28d. Describe how injury occurred					
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	ne Hospital	Medical	29a. Certifier LECertifying Physics (Check only one) 2 Medical Examination	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurre estigatio	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
	To the within 2 To the I complete	Me	29b. Signature and title of certifier	10			c. License nu				Date signed (Month, Day, Year)		
,			30. Name and address of person who co	mpleted cause of death (Ite	am 23a) (Tyne F	Print)		9643			11,20		
			Jessica Rab	emo Joi	n Ns Hopi	KINS	BAY	View t	tosp. E	ASTE	ERN A	VE. BALTO. MD	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 3 2005	32. Registrar's Sign	nature	1							

			For State	State of Ma	ryland /		rtment of H		Mental	Hygien	71115	33073
	7	2	1. Decedent's Name (First, Middle, La	ist)						of Death		3. Time of Death
*	Physicia /Medic		Jovce		r _		Horto	n	OCTO	1		5 12:50 PM
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7	Funeral Director			Sex 7. Age 1 ☐ M 2X F	(In yrs. last 60	Yrs.	Months Days	Hours Mir		of Birth th, Day, Year 17	45	nthplace (State or Foreign ountry) NA
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	anylan show	<u>.</u>	10a. State 10b. County		10c. City, To							10d. Inside City Limits 1 XYes 2 No
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Itema 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at 90cs.	ai Dir	4003 McDowell	Lane				227		10g. 0	U.S.	*
	r dea	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes into Rican, e	or No-	14. Race - Am Black, Wh	
36	rs afte	by Fi	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes XXN If Yes, Give Year or Dates:	0	1	I□Yes 2🛛 No	Specify:			Specify:	Black
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Maryland	d be fi	o Be	17. Father's Name (First, Middle, Las Grady Horton	u)				Louis			n Sumame)	
ary	shoul nd Me mark umati	2	19a. Informant's Name/Relationship	(Type, Pnnt)	1	9b. Mailin	g Address (Street	and Number or F	Rural Route	Number, City	or Town, State,	Zip Code)
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altimore,	of He		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place ceme	of Dispo etery, cren	sition (Name of natory or other plac	e)	Date	20c. l	_ocation - City o	r Town, State
Ē	: Pag tment tant: tant:		4 ☐Donation 5 ☐Other (Spec	ify)	M		ion		15/0	5 Bal	ltimor	e, Md
Bai	Depar Impor eny in		21. Signature of Funeral Service Lice	C. OX	ugh	# Ma	Name and Address arch F/E 300 Waba	West sh Ave	, Ba	ltimo	ce, Md	21215
- 3			23a. Pag1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. D		•					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Multi	ple 1	Hen	norrha	gic.	Stro	KR		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	ce of):		7				1
~		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequenc	ce of):						
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6								
oʻ	e exec	Еха	resulting in death) Last	Due to (or as a	consequenc	ce of):						
8760,	cate be executed physicien and ; the burial-transit	dical	•	d								
9		/Ме	IF FEMALE:	23c. If yes, outcome	of pregnancy						22d Date of de	Nivor
.O. Box	es that the death certific igned by the attending F be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetat dea	ath 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
o.	t the d by the ached	hysi	9 Unknown	9□ Unknown								
ď,	ss thangned I	by P	Part II. Other significant conditions	contributing to death bu	it not resultin	g in the ur	nderlying cause give	en in Part I.	236		\	to the cause of death?
ord	w require been si should I	ted				-				1 ☐ Yes 2	2 5 8€No 3 □ F	robably 4 Unknown
ec	a 8 0	Completed							24a	. Was an autopsy performed?	24b. Were a prior to death?	utopsy findings available comptetion of cause of
a	sicien: The law certificate has t irector, page 2 s			Т						Yes 2 N		
₹	Physicien: r this certifical ral director,	To Be	25. Was case referred to medicat examiner? 1 Yes 2 Yes	Hospital: 1 Inpatie	nt 2 ER/	/Outnatien	t 3 DOA Oth	26. Place of D			6 □Other (Sp	acutul
٥	g Phy er this neral c		27. Manner of Death	28a. Date of Injur (Month, Day	y 281	b. Time of				cribe how inju		
Š	Attendin death. ctor: Aft y the fur	atio	1 Accident 5 Pending investigation	on		,,		Yes 2 □ No				
Division of Vital Records,	l or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At home :. (Specify)	, farm, str	eet, factory, office			ation (Street a or Town, Stai		lural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C		Physician: To the best of aminer: On the basis of and manner sta	examination							
	o the vithin o the omple	Med	29b. Signature and title of certifier	and maining 5(d			29c. Licens	e number		29d. D	ate signed (Mor	th, Day, Year)
)	⊢ <i>≶</i> ⊢ ö		A francis	No.	n. D		PI	950=	+	00	tober	10, 2005
	1).		30. Name and address of person who	completed cause of de	eath (Item 23	la) (Type,	Print)		2	0.5		
	8		31. Date filed (Month, Day, Year)	on Hue	Lnue ir's Signature		Balt	imore	< ,	IND	212	27
	Sta Regist		OCT 1 3	20	urs signature	1	barli					

Horton, Joyce

		_	State of M			rtment of H			•		gible.	
		1 - State Registrar		, ,	-	tificate of				eg. No	005	33074
Bh si		Decedent's Name (First, Middle,		il	- 1/	1			2. Date of Dea Month		Year	3. Time of Death
Physic /Med		Johnnie	Lee	1-10	ark	les.	2		10	10	05	6ZOAM
Exam		4a. Fecility Name (If not institution	- 21 1	Coin.	100	4b. City, Town, o				4c. Co	unty of Death	
		Baltimore VA	Medical	Cen-		If Under 1 Year	If Under 2	(Orc				
Funera Director		5. Social Security Number 251-26-5548	6. Sex 7. Ag 1	je (In yrs. la	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 3-5-2		9. Birthi	olace (State or Foreign ntry)
		Usual Residence of Decedent		82					3-3-2	J		s.c.
rylan	_	10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits
Ba-f s	octo		NA		Balt	7						XXYes 2 □ No
with the	Dire	10e. Street and Number				10f. Zip Code			1		of What Cou	ntry?
eath y	eral	4320 Claraway	Apt. Q 5	Ever in II S	12 14		L213	in? (Sne	ofy Ves or No-	US	Race - Ameri	can Indian
fter d	by Funeral Director	1 Never Married 2 Marrie	Armed Forces?			Vas Decedent of H Yes, specify Cuba	an, Mexican,	Puerto F	Rican, etc.)	1.4.	Black, White,	
ours a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify:			Sp	ecity: B	lack
illed within 72 hours after death with the Maryland Hygiene Hygiene than "natural", or Itams 23a or 28a-f show ant, the Modical Evant or matter the modified at	Completed	15. Decedent' (Specify only highest			(Give I	ent's Usual Occup	during most	of workin	ng	16b. Kind	of Business/In	dustry
within ne.	lg II	Elementary/Secondary (0-12)	College (1-4or	5+)		O NOT use retired	d)			_		-
Hygie thar t	ပိ	8th grade 17. Father's Name (First, Middle, L	ast)		Lak	orer	18. Mother	r's Name	(First, Middle,		. Rail	road
id be ental ked o	To Be	Judge	,	Hark	less				(,,		,	
d I yid I U Z I Z 2 should be filed with and Mentat Hygiene. Is marked othar the aumatic evant, Tre I	-	19a. Informant's Name/Relationsh	ip (Type, Print)			g Address (Street	and Number	r or Rurai	Route Number	r, City or To	own, State, Zip	Code)
If \$\int\$, INTALY INTELLIGATION \$1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Event her invail to incline at		Fannie Mae Thor	mas Si	ster	214]	Leavens	sworth	Rd.	, Darli	ngton	, S.C.	29540
of He of He roth		20a. Method of Disposition 1 □Burial 2 □ Cremation	3 DRemoval from State	20b. Pla	nce of Dispos metery, crem	sition (Name of atory or other place	ce)	Di	ate	20c. Locat	ion - City or To	own, State
Pages ment of lant: If its		`4 Donation 5 Dother (Sp	ecify)	Gar	rison	Forest \	/et.	10-1	7-05	Owin	gs Mil	ls, Md.
parmit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L	icensee	1		Name and Addre	a American		Baltimo			202
		23a. Part1. Enter the disease, or o	complications that cause	t the death	-	arch F.H.			1101 E.		n Ave.	Approximate
		shock, or heart failure. List of	only one cause on each li	ne.		i the mode of dya	ig, such as c	al Glac O	respiratory arr	est,		Interval Between Onset and Death
Physician /Medical	_	disease or condition resulting in death)	a LA CTIC Due to (or as								-	
Examine	_		RESPI			HLURE						
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as			100110						
ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	с.									
ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):							
OI VILGI DECOLOS, F.O. DOX 00/00, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dlcal		d.									
es that the death certific igned by the attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of delive	arv
death a atter	iclar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	/			1/1	Month	Day Year
by the lache	hys	9 Unknown	9□ Unknown									
gned be de	by P	Part II. Other significant condition	ns contributing to death b	ut not result	ting in the un	derlying cause giv	ren in Part I.					he cause of death?
w require been sign	ted								1 🗆 Ye	es 2∐N	lo 3 ☐ Prob	pably 4 🖫 Unknown
has b	Completed								24a. Was a autops	v l	prior to co	psy findings available mpletion of cause of
ian: The									perform 1 Yes	2 No	death? 1 🗆 Yes	2 No
sicial certil	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ont 2□=	R/Outpatient	3□ DO∆ Oth			(Check only on 16 5 ☐ Reside		1045-1-10-1-1	
JII OI VIIGI NEG Jing Physician: The lav After this certificate has funeral director, page 2 !	H-	27. Manner of Death	28a. Date of Inju		28b. Time of	28c. Injur	y at		8d. Describe ho			y)
ath. rr: Afte	atlo	1 ■Natural 5 ☐ Pending 2 ☐ Accident investig	ation	y rear)	Injury		κ? Yes 2∐N	lo				
r Atte	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	289. Place of In	ury - At hom c. (Specify)	ne, farm, stre	et, factory, office		2	8f. Location (St City or Town	reet and N	umber or Rura	al Route Number,
urs aft												
To the Hoapital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only 2 Medical S	Physician: To the best exeminer: On the basis of and manner st	f examination	ledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and pinion, death	l place, a n occurre	nd due to the ca d at the time, d	ause(s) and ate and pla	d manner as s ice, and due to	tated. o the cause(s)
o the ithin 2 o tha omple	Mec	29b. Signature and title of certifier	and manner st	atou.		29c. Licens	e number		2	9d. Date si	gned (Month,	Day, Year)
F ₹ F 8		1 fet of	H.D.			P17	1643				10, 20	
1 L1		30. Name and address of person v	who completed cause of o	leath (Item 2	23a) (Type, F	Print)						
1+1		WEN-YEE TSAI	M.P. 101	1. GREC	ENE S	T BALT	14012	E , 1	10 21	201		
	tate	31. Date filed (Month, Day, Year) OCT 1 3 2	2. Registi	ar's Signatu	THE STAN	D.						
Regis	trar	OCT 1 3 2	UUD DEPENDE	. F.S.	1							

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			For State	State 0	i iviai ytai i		ficate of		i wentan n		2005	33075
	_		Registrar 1. Decedent's Name (First, Mid.	dle last)		Oera	neate of	Death	2. Date of D	Reg. No.	. = 0 0 0	3. Time of Death
-	Physici	an	Allera : H	5-1-11	TI Ha	/ Inali			Octob	Day	Yeer 1 2005	6:55 A M
F	/Medi		4a. Fecility Name (If not instituti	DERENI/	mber)		th. City. Town. o	or Location of De			County of Deeth	
	Examir	ner					,					
Ĕ,	Funanal	1000	Greater Bal 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year			irth	Baltim 9. Birth	place (State or Foreign
6	Funeral Director		WKNOWN	1 □ M 2 🗗 F		Yrs.	Months Days	Hours Mi	(Month, D	HOD:	5 000	intry) MD
10	and the second		Usuel Residence of Decedent									
0	rylan		10a. State 10b. Coun	ty	10c. Cit	y, Town or Loca	tion /_	- · · · · · ·	11-	1		10d. Inside City Limits 1 ☐ Yes 2 🗷 No
_	ith the Marylar or 28a-1 show	cto	MU BAL	TIMORE	BA.	1/14	DREIM	MANDAL	15/0W	N		
<u>.</u>	death with the Maryland rms 23a or 28a-f show	Funeral Director	10e. Street and Number	1-1-	>		10f. Zip Code	120		10g. Cit	tizen of What Cou	intry?
-,-	s 23e	a		SIDEK	D.	0 10 111	5/1	<i>55</i>	(Canada Van es N		14. Race - Ameri	ican Indian
	after dea	une	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Fo	edent Ever in U. orces?	.5. 13. W	es, specify Cub	oan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	Black, White	
3 6	rs aft	by	3 Widowed 4 Divorce	If Yes, Gr	ve	10	Yes 2006	Specify:			Specify: B	LACK
14e	72 hours after natural', or ite		15. Decede	ent's Education		16a. Decede	nt's Usual Occup	pation		16b. K	ind of Business/Ir	ndustry
7 2	within 72 ene. than 'n	ple	(Specify only high Elementary/Secondary (0-12	nest grade completed) College (1-4or 5+)	life. DO	NOT use retire	during most of wood)	vorking	1	I EQUIT	_
- 5	filed within Hygiene.	Completed	Ø	L	~	INF	ANI			IN	777/1	
0	be filed ital Hygi d other	Be (17. Father's Name (First, Middle	e, Last)	12			18. Mother's N	lame (First, Middle	e, Maiden	Sumame)	
	should be nd Mental marked o	10	WILLIAM	HOLLA	VD			DEH	-y 1700	-47	740	
Loud	ie, intal ylatifu Z iz iz 2000. I and 2 should be filed within 72 hours after death with Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Experience multile.	1 3	19a. Informant's Name/Relatio	nship (Type, Print)	BEI	19b. Mailing	Address (Street	t and Number or	Rural Route Numi	. /	-	ip Code)
	and and m 27		VILLIGHTIYEL	-Y HELLAND) 2056	Hace of Disposi	ERNS)	ひと ハン・	Date		Ocation - City or T	Our State
土	Pages 1 nent of H int; if ite		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation			semetery, crema	tory or other pla	ice)	1770	Q. Da-	TIM. 07	AND COLORADO
ع حلــ			`4 □Donation 5 □Other		WRE	en Moi)U)	16,000	DI	1 UNDICE	MERCHAND
	permit. Departnimports any inju		21. Signature of Funeral Service	Lidensee		1/2	Vame and Addre	ock DE	JENKY W.	DON	NO DO	N5 CO.
			23a. Part1. Enter the disease,	or complications that	Caused the deat	h. Do not enter	the mode of dv	on such as card	iac or respiratory	arrest	1100	Approximate
		8	shock, or heart failure. Li Immediate Cause (Final	ist only one cause on e	each line.				,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.	Unkno				17.100			
- 1	Examiner	4		EV:2	(or as a conseq	derice of).	Vatra	DITT				240 28 win
		<u>~</u>	Sequentially list conditions,	b. Gue to	(or as a conseq	1001	7/1/00	114			- 1	The State
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	uted	uju.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	TRE	TERM	PREMI	TURE	-RUDI	TURE E	V= K	SIYBRAN	108-1011 105 2005
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(CE)	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond 25. Was case referred to mediaxaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen inve 3 Suicide 6 Cou dete 29a. Certifier (Check only one) 29b. Signature and title of certifications	23c. If yes, ou 1 Live t 4 Pregregation Pregregation Live t (Mor. Stigation 28a. Date (Mor. Stigation 28a. Date (Mor. Stigation 28a. Place build 28a.	(or as a consequence of pregnation to the composition of pregnation to the composition of	ancy al death 3 E E E E E E E E E	3 DOA Ot 28c. Inju Wc M 1 cot, factory, office occurred at the t stigation, in my	26. Place of Ether: 4 Nursing Lary at ork? Yes 2 No	23e. Did 1 24a. Wa aut per 1 Yes Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	tobacco (Yes 2 s an oppy formed? 2 Moone) sidence how injut (Street ar own, State e cause(s), date and	23d. Date of delix Month use contribute to No 3 Pro 24b. Were aut prior to codeath? 1 Yes 6 Other (Spectry occurred) and Number or Rule) and Number and due when sheet in the shrined (Month)	the cause of death? shably 4 □Unknown topsy findings available ompletion of cause of 2 □ No trify) ral Route Number, stated, to the cause(s)

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	Physici		Decedent's Name (First, Middle, Las Tyrone Harrison	0					2	Date of Dea Month	- 500	Year 200	3. Time of Death 0235 PM
	/Medi Examir		4a. Facility Name (If not institution, give ST. AGNES HOSPITI	AL, 9003 CAT		I	BALT	MORS	٤		4c. Co	unty of Death	
*	- Funeral Director		5. Social Security Number 6. Sec. 487–76–6859 Usual Residence of Decedent	7 M 2 T E	In yrs. last birth	rs. Month	der 1 Year s Days	ff Under 24 Hours	Min.	Date of Birtl (Month, Day ov 27,	, Year)	Cou	* *
	Maryland a-f show	tor	10a. State 10b. County MD	1	Oc. City, Town	or Location							10d. Inside City Limits 1√2 Yes 2 □ No
	thin 72 hours after death with the Maryland e an "natural", or itsms 23a or 28a-i show Mealical Examinat must be rodified at	eral Director	10e. Street and Number 6313 Monika Plac 11. Marital Status	e 12. Was Decedent Ev	er in II S			1207	n? (Speci			of What Cou USA Race - Ameri	,
9800	ours after d	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give X Year or Dates:			ecify Cuba 2 X No	n, Mexican, I	Puerto Ri	fy Yes or No- can, etc.)		Black, White,	
Maryland 21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NOT	work done	during most o	of working		16b. Kind	of Business/In	dustry
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	ies 1 and 2 shi of Health and of item 27 is m or other traum		19a. Informant's Name/Relationship (7 Charles Richardson 20a. Method of Disposition 1 Burial 2 Cremation 3	n/partner	631 20b. Place of	l3 Mon	ka Pl	Lace Ba		nore, M	ID 21	own, State, Zip .207 ion - City or To	
Baltimore,	permit, Pag Department Important: any injury o		4 Donation 5 NOther (Specify 21. Signal re of Funeral Service) icens		for	22. Name State Baltir	Anat	ss of Facility Omy Bo	ard (1201	655 W.	Balt	imore S	Street
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8760,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ACQUIRE Due to (or as a of the control of the c	O I	MMUM	10 DE	FICIE	NCY	Syn	IDRO	ME.	2 YEARS
O. Box 6	at the death certific by the attending p tached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other		,			23d	. Date of delive	ery Day Year
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significant conditions of ACUTE APPEI		not resulting in	the underlying		on in Part I.			bacco use es 2□N		he cause of death?
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/ita	ilcian: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?	11- 3-1					of Death (Check only or	10)		
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Divisio	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, far (Specify)	m, street, fact	l	Yes 2 □ No		Location (S City or Tow		umber or Rura	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifying Phy (Check only one)	ysician: To the best of liner; On the basis of e and manner state	xamination and	death occum Vor investigati	ed at the tin on, in my o	ne, date and pinion, death	place, and occurred	d due to the d at the time, d	ause(s) and late and pla	d manner as s	tated. o the cause(s)
)	To T To I	Σ	29b. Signature and title of certifier Meuri	Mi			9c. Licens		36			igned (Month, 04, 2	
			30. Name and address of person who of	I ST. AL	GNES	Type, Print) UDS P							PALTIMORE
	St Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	we							

MARRISON

TYRONE

			State of Maryland / Department of Hea 1- State of Maryland / Department of Department	Ith and Mental Hy	9	5 33077
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARJORIE MARCELLA JONES	2. Date of De Month October	9 ZOOS	
	Examin	er	4a. Facility Name (If not institution, give street and number) Sinai Hospitel of Boltiwor Boltiwor	- 1/	4c. County of Dea	
	Funeral Director		218 · 28 · 6385 1 M 2 S F 73 Yrs. Months Days He	Under 24 Hrs. 8. Date of Bir (Month, Date of Control of	1032 9. Bir	thplace (State or Foreign puntry)
	death with the Maryland ms 23e or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE GWYNN OAK			10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	with the	Direc	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
920	7.72 hours after death with the Marylar "neturel", or items 23e or 28e-1 show circal Examitrer institute motified at	by Funeral Director	' 3 Kg Widowed 4 □ Divorced	nic Origin? (Specify Yes or No exican, Puerto Rican, etc.)		te, etc.
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12.1H GRADE N A 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) SEAMSTRESS	g most of working	16b. Kind of Business	Andustry
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	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and It MARGARET RANDAU (SISTER) 3616 GWYNN OA			-
ore,	ges 1 and it of Health if item 27 or other tr	1 (1	20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore,	Pa mer ent ury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of	10-12-2005	BALTIMORE	Mo
B	permit. Depart Import eny inj			I PIKE, BALTO.		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The cerebrel He morr keys are put of the consequence of the consequ	ch as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in End Stafe Kidney Diseas, Hyperteuriou, Diebeth, Hyperlipidemie, Congestire Heart Jei	Part I. 23e. Did t	tobacco use contribute to Yes 2 ☐ No 3 ☐ P	
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Vita	sicien: certific irector,	o Be	25. Was case referred to medical examiner?	Place of Death (Check only		
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	e Hosp 24 hou e Funei etely fil	Medical	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, discovering the control of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to the n, death occurred at the time,	cause(s) and manner as date and place, and dur	s stated. e to the cause(s)
	To the within 2 To the complet	Me	200. Orginated and third of southern		29d. Date signed (Mont	
•	1/2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	000 Hospital st	Uctober 9	, 2002
,)		GITANA BRADAUSKAITE, MD Since	Hospital st	- Boltivec	n
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 3 2005			

Patient Knawn a: MARJORIE N JONES

State of Maryland / Department of Health and Mental Hygien 33078 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Elsye M. Johnston OCT 2005 3:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Assisted Living Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√ F Hours Director 234-80-6501 91 AUG 30 1914 Canada Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r then "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7110 Minstrel Way 21045 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Ite may injury or other traumatic event, the Mydical Examine ADE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Garnet Benson Dora Mary Ditmars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah M. Rempert/daughter 3006 Woodberry Lane Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory. Inc. 10/13/05 Baltimore, MD 21. Signature of Funeral Service Cremation Society of Maryland, Inc. Dawn F. McDonald

299 Frederick Road Baltimore
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cayse on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CED **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown ete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2[Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Assisted 1 ☐ Yes 2 No Hospital: ٩ 1 Inpatient the funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d, Date signed (Month, Day, Year) 2005 person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number, 4c. County of Death Examiner HOSDITON 1 timo If Under 24 Hrs. (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 ▼ F Director 219-42-1704 Yrs Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location iam 27 is markad othar than "natural", or itams 23a or 28a-1 show othar traumatic avant, the Modical Examinar must be notified at 10d. Inside City Limits Director 1 Tes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 1213 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 shoutd be filed within 7 h and Mental Hygiene.
7 is markad othar than "r Colfege (1-4or 5+) dary (0-12) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Dep rument of Health as Important: If itam 27 is any injury or othar trau once. 20b. Place of Disposition (Name of Balto-MD Oa. Method of Disposition 1 Burial 2 Cremation emoval from State ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M0136 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or responds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, bauting to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit Diabete attending physician and resulting in death) Last Due to (or as a consequence of). P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 2 No 1 ☐ Yes 2 X No 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check on one examiner? Cther: 1 Yes 2 No 2 1 Inpatient 2 FA/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury Month, Day Year) funeral 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 65 investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number -53298

DHMH 17 Rev 1/2001

Registrar

DICU

31. Date filed (Month, Day, Year)

OCT 1 3 2005

Hopkily

Hospit

600 N. Branown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

			1 10430 1	State of Maryland						_		
			For State Registrar	Otate of Maryland	•	tificate of		-	Reg. No.	2005	33080)
			1 Decedent's Name (First Middle Last)	1 - 1 /				2. Date of De	eath		3. Time of Death	_
	Physici /Medic		ISAIAH MA	LIKJENK	1117			SEPT	Day 2	3 2005	5 04:26	_
	Examin		4a. Facility Name (If not institution, give s				r Location of Deat		4c.	County of Death		
			MERCY MEDIC		at foliationia)	If Under 1 Year	1 ORE CI	,	db.	BATTA		_
	Funeral Director		5. Social Security Number WK 6. Sex	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.		ay, Year)	2005 M	pplace (State or Foreign	
	Q		Usual Residence of Decedent					13611				_
	arylar show	7	10a. State 10b. County		Town or Loc						10d. Inside City Limits 1 Yes 2 □ No	
	28a-f	ecto	10e, Street and Number	DAL	TIMO	10f. Zip Code			10a Citi	izen of What Cor		
	Sa or	בַּ	620 MOSHER	4		212	17		rog. On	45A		
	ilied within 72 hours after death with the Maryland Hygiene. yther then "naturel", or flams 23a or 28a-f show ent, the Medical Examinar must be nyillisd at	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	13. V		dispanic Origin? (S an, Mexican, Puer	Specify Yes or No	0-	14. Race - Amer		_
9	or its	/Fui	1 Never Married 2 Married	1 Yes 2 No		Yes 2/25-No	Specify:	to rican, etc.)		Specify: BLA		
003	urel',	d by	3 Widowed 4 Divorced	Year or Dates:					10-10			_
1 5-	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I life. L	ent's Usual Occup kind of work done OO NOT use retire	ation during most of wo d)	rking	160. KI	ind of Business/f	naustry	
212	iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		N/A						
밀	tal Hyg	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle				
yla	should b nd Ments marked imatic e	To	UNKNOWN					ETTA				_
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or items 23a or 28a-f show appring yor other traumatic event, the Madical Excinition must be notified at ance.		19a Informant's Name/Relationship (Ty)	De, Print)		-	and Number or Ri					
	1 and Healt 10m 2		MOTHER 20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of	Ţ	Date Date		ocation - City or 1		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other onca.		1 ☑Burial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	datory or other place. Cemetery	· 1	/2005	Wood	lawn, M	arv1and	
altii	mit. F partme sortar / injur	i	21. Signature of Funeral Service License			The second secon	ss of Facility Ashton					-
m	Depa Impo any ii		1 Edward L	enterns	- 1	736 Edmo	ndson Av	enue; Ca	atons	sville,	MD 21228	
*			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. ie cause on each line.	Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	risom	1	3					Onset and Death	
H	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):							
		e.	Sequentially list conditions, if any, leading to immediate). Due to (or as a consequer	nce of):					-		-
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Decate of Mylly) that initiated events									
oʻ	ate be executed sysicien and he burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):							
8760,	ate by	dical	d	i								_
x 68	death certificat e attending phy d for use as th	Physician/Medi	IF FEMALE:	3c. If yes, outcome of pregnanc	ev e	200				23d. Date of deli-	ven.	
Вох	atten affor u	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)	/		1	Month	Day Year	
o.	that the do ed by the detached	hys	9 Unknown	9 Unknown								
S, P	s C e	by P	Part II. Other significant conditions con	tributing to death but not resulti	ing in the un	derlying cause giv	ren in Part I.			17	the cause of death?	ŀ
ord	w require been sig should t							1 🗆	Yes 2	DX(vo 3 □ Pro	obably 4 Unknown	i
Records,	aw as b	ompleted						24a. Was	psy	prior to c	topsy findings available ompletion of cause of	
alF	Th ate	O							ormed? 2 X No	1 Yes	№ No	_
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	R/Outpatient	3 DOA Ott	ar.	ath (Check only		6 □Other (Spec	rifu)	7
ı of	g Physical this seral di	H-11	27. Magner of Death	The state of the s	8b. Time of Injury	28c. Injur	y at	28d. Describe			,,	7
sior	Attending F r death. sctor: After by the funering	atio	1 Alatural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2 □No					
Division	of or Attend after death Director: , d in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To			ral Route Number,	
Ш	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge death	occurred at the tir	me date and place	and due to the	Calleb(e)	and manner as	stated	
	Hospitel 24 hours Funerel letely filled	Medical	(Check only 2 Medical Examinone)	nar: On the basis of examination and manner stated.	n and/or inv	estigation, in my	ppinion, death occi	urred at the time,	, date and	place, and due	to the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Dat	te signed (Month	177	_
) // X Cherry	May h		D-00	X43985		SEX	OT, 23	2005	
V	RH.		30. Name and address of person who co		(Type)	Print) P	ATA	10 21	207)		
1	اران Sta	10		32. Registras Signatur	re 1	Acces 5	11010	10 01	201			_
	Sta Registi		OCT 1	32. Registre's Signatur 3 2005	J.	BONNE						

DHMH 17 Rev 1/2001

Registrar

Lamont Kennedy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06849 State of Maryland / Department of Health and Mental Hygiene RPD 1 - State Registrar Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** enned amont 8, 2005 October 0230 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner I 295 North @ Annapolis Road Baltimore 8. Date of Birth (Month, Day, Year) DEC 2. 19 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 214-90-1 XM 2 F 2312 Director marylan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or cocation 10d. Inside City Limits or Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country 10e. Street and Number rmIT by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White etc 1 Never Married 2 Married Yes 25 Baltimore, Maryland 21215-0036 1 Yes 2 No 1a(Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel". Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ware Houses al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ware House MAS oth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event once. Be Kennedu Cherylene -amont 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hawkins-Sister 241 eto mai 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 ☐ Gremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 10/15 Cemeters 0 21. Signature of Fineral Selvice Lice 22. Name and Address of Facility Pimarch Puncial Hone of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fear failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) lulte **Physician** Ole /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 2 Yes 2 \(\bigcap \) No 24a. Was an autopsy performed? Yes 2□ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ Nother (Specify) at Scene Certification: To 1 Yes 2 □ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury Month, Day 27. Manner of Death 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation Pedestrian St 1018105 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu motor vehicle(s) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1395 North 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 North (C Baltimore MI) 4 🗀 Homicide Inter Annapalis state thehway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

OCT 1 3

ldu ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

October 8, 2005

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year Physician Arthur Charles Kreiger 2045 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 317 Race Street Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1∏ M 2□ F Yrs Director 213-16-9772 Oct 11, 1917 87 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Department of Heatth and Mantal Hygiene. Important; or frems 23s or 28s-f show important; if frem 27 is marked other than "natural", or frems 23s or 28s-f show important; if them 27 is marked other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√2 No Funeral Director MD **Allegany** Cumber1and 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 317 Race Street 21502 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 watch maker jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Abraham Kreiger Marie Alice Whitacre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Kreiger/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c Date

20c Date

20c 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee Ronald S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street won Baltimore, MD 21201 a. Pert1 Enter the diseate, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner attanding physician and for usa as the bunal-transit or Attending Physician: The law raquiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 TNO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) Certification: To 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) within 2 To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DO017563 Oct 8 2005 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 62 V21e, 17 1 21501 god Neti 13011 ino 31. Date tiled (Month, Day, Year) 32. Registrer's Signature State

Registrar

OCT 1 3 2005

			For State	State of Maryland / Dep			7005 33086
			Registrar	Ce	rtificate of Death	Reg. No.	3. Time of Death
	Physicia	_	Decedent's Name (First, Middle, Last)	-		Month Day	Year
	/Medic	al	Virgil	Long	4b. City, Town, or Location of Death	9 23	2005 5:15 a M
7.	Examin	c,	4a. Facility Name (If not institution, give si Bayside Care Cent		Lexington Park		. Mary's
79.5		-	5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director	-	579-58-2312	M 2□F 59 Yrs.	Months Days Hours Min.	11/5/45	WASHINGTON DC
	pe .		Usual Residence of Decedent	10c. City, Town or L	contino		10d. Inside City Limits
	anyla ehov	'n	10a. State 10b. County	DATO ANTOLIN	ONLOCALITE		1 Pres 2 No
	with the Maryland a or 28a-f ehow	Funeral Director	10e, Street and Number	TRYS IMECHI	10f. Zip Code	10a. Citi	zen of What Country?
	with be or	۵	40845 KING [)in	201,59	1 14 1	ITED STATES
	death	era		Was Decedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Sr		14. Race - American Indian,
9	after o		1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Hican, etc.)	Black, White, etc.
5-0036	72 hours after naturel', or Ite	d by	3 ☐ Widowed 4 Divorced	Year or Dates:	TE 163 ZE 140 Specify.		Specify: BLACK
5	be filed within 72 hours after death with the Marylar ital Hygiene. and Hygiene. do other than "naturel", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		nd of Business/Industry
2121	within ene. then "	шc	Elementary/Secondary (0-12)	College (1-4or 5+)	C SALES PER	SON SEL	LF EMPLOYED
	Hygi ent, 1	0	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maiden	
Maryland	Aental Aental rked tic ev	To B	MAURICE L	DNG	MINNI	E MACI	DANT
ary	and M and M le mar		19a. Informant's Name/Relationship (Typ	1 -	ling Address (Street and Number or Ru		r Town, State, Zip Code)
•	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		BARBARA WARD	SISTER 4084		HANICSVILL Date 20c. Lo	E,MD 20659
Ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disp cemetery, cre	ematory or other place)	20c. Lo	ocation - City or Town, State
Baltimore	Department Pag Department Important: Important: I		4 Donation 5 ☐ Other (Specify)	ANATOM	Y GIFTS KB 912 22. Name and Address of Facility Bri	3105 HAI	OOVER, MD
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22955 Hollywood Ro		·
74			23a. Part1. Enter the disease, or ompto shock, or heart failure. List only on	3/ /////////	•		Approximate
5	Physician		Immediate Cause (Final	e cause on each line	as F. D. SA		Interval Between Owset and Death
)	/Medical		disease or condition resulting in death)	Due to (or as a consequence of)	any and is		ceeses
3	Examiner		Sequentially list conditions D	End Slo	ege COPD	1	years
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):			4.
	be executed icien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of):	V		V
8760,	be executed sicien and burial-transit	alE		540 to (0. 45 a 55.165q45.165 5.7).			
687	ate The	edical	0	-			
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3			23d. Date of delivery
	death te atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		☐ Other (specify)		Month Day Year
P.0	at the de I by the a stached	Phys	9 🗆 Unknown				
	res that signed to be dete	by	Part II. Other significant conditions con	thibuting to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death?
oro	w requir been si should	eted	70000	coco tes	•		
Vital Records,	e law has t	Completed	Casai	omyopaloy		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a		e Co	25. Was case referred to medical		20.00	1 ☐ Yes 2 € No	1 ☐ Yes 2 ☐ No
<u> </u>	Physician: T this certificat ral director, p	To Be	examiner?	ospital: 1 Inpatient 2 ER/Outpatie	Other	th (Check only one) ome 5 Residence	6 □Other (Specify)
o			27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how injur	
io	돌은중화	atio	1 ■ Natural 5 □ Pending investigation	(Month, Day You)	M 1 ☐ Yes 2 ☐ No		
Division	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	streel, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	ospitat or A hours after uneral Directly filled in by						
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical		sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.			
	o the	Me	29b. Signature and title of certifier	$\Delta I = 0$.	29c. License number	29d. Dat	te signed (Month, Day, Year)
	/		1 James	VA BOXOFM	H) DOB	417 9	-23-05
,	1		30. Name and address of person who co				
			James P Jarboe,		Road, Hollywood,	MD 20636	
	Sta Regist		31. Date filed (Month, Day, Year)	5 Registrar's Signature	parti		

		1	For State Registrar	State of Maryland / Dep	partment of Health and I e <i>rtificate of Death</i>	Mental Hygien Reg. N	2 005	33085
	Physicia		1. Decedent's Name (First, Middle, Las	IN LONG		2. Date of Death Month Di		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Death		c. County of Deatl	
	Funeral		4 63 04 DKHY 5. Social Security Number 6. So		y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birtl	hplace (State or Foreign
	Director		579-70-6404 1 Usual Residence of Decedent	□ M 2 X F 5 6 Yrs.		11/16/4	1 101-	+10
	Aaryland f show	ō	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits 1 ☐ es 2 ☐ No
	ith the A or 28a-	Director	10e. Street and Number	TRYO LUNY	10f. Zip Code	10g. C	itizen of What Co	untry?
	Jeath w	rai	46204 DRA'		3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "neturel", or items 23a or 28a-f show event, the Madical Exertirer must be inclined at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 Ho If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	o Hican, etc.)	Black, White	PAITE
2-00	72 hour	eted l	15. Decedent's Ed (Specify only highest gra	fucation 16a Dec	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	rking 16b.	Kind of Business/	Industry
2121	e filed within al Hygiene. I other than ' vent, the Ma	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)	ANAGER	F	CETA	1
Maryland 21215-0036	d ta b	Be	17. Father's Name (First, Middle, Last)	JOHN ROPNE	18. Mother's Nat	ne (First, Middle, Maide	n Sumame)	T)-1
lary	2 should by and Menta is marked eumatic er	2	19a. Informant's Name/Relationship	Турө, Print) 19b. Ма	ailing Address (Street and Number or Re	ural Route Number, City	or Town, State, Z	Zip Code)
	1 and Health em 27 ther tr		EDNA BOOTHE 20a. Method of Disposition	cemetery c	sposition (Name of rematory or other place)	Date 20c.	Location - City or	Town, State
Baltimore,	t. Pages tment of tent: If it		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific	PNATON	N 6) FTS REG. 10/ 22. Name and Address of Facility	8/05 HF	HUDVE	FR, MD
Bal	permit. Departr Importe eny inji		21. Signature French Service Light	isee	Daugherty Family Funeral F			
			23a. Flant1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	.9	enter the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Guobustoma Due to (or as a consequence of):				6 mos
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b				
	ecuted and I-transit	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c				
8760,	icate be executed physician and s the burial-transit	dicai E	· ·	d				
Box 68	eath certifica attending pt I for use as th	an/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ⊟Ectopic pregnancy		23d. Date of deli	
P.O. B	at the deat by the attertached for	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		5 Other (specify)		Month	Day Year
	quires that n signed b uld be deta		Part II. Dther significant conditions of	contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	A	o the cause of death?
Division of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital	Physicien: The I r this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)		
u of	ng Phys ter this neral dii	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury at Work?	dome 5 Residence 28d. Describe how inj		спу)
risio	Attendir death. ictor: Al	Certification:	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street	and Number or Ru	ural Route Number,
á	oitel or A urs after orel Dirac		4 Homicide	building, etc. (Specify) nysician: To the best of my knowledge, de		City or Town, Sta		actated
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	niner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occ	urred at the time, date a	nd place, and due	o to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	ALM?	29c. License number D28544		Date signed (Monti	
1	2		30. Name and address of person who	completed cause of death (Item 23a) (Tyl	pe, Print)			Miscin
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	NU SIEIUI LEUN	VARDTOWN	D'INITO	10020
	Regist	rar	OCT 1 3	2005 Jenson 15.	Soule			

State of Maryland / Department of Health and Mental Hygieney 33086 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** YOWARD 02 200 /Medical om 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College REDER Inder 1 Year ma REderick Vieu If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Months Days Hours 1 2 M 2 □ F Yrs. 212-14-6268 84 -23-1921 Director Thurmont, Usual Residence of Decedent 10a. State 10c. City, Town or Location itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic avant, the Macilcal Examinationals by motified at 10d. Inside City Limits MD Frederick Frederick Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7017 Kelly's Store Rd. 21788 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avant, It's Ma Elementary/Secondary (0-12) College (1-4or 5+) 10 Owner/Operator Liquor Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Russell Lewis Glenn K. Weller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7017 Kelly's Store Rd., Norris Lewis, Son Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State Fairfield Union Cem 10-6-05 Fairfield, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityJL Davis Funeral Home 12525 Bradbury Ave., Smithsburg, MD 21783 23a. Pany Linter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Physician HEART yrs /Medical Due to (or as a consequence of) **Examiner** 41) CONOMANS 10 ANZEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ COPT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif -31912 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULO MENOIA MO 1564 DPOSCUMDOWN PINE, FREDERICH MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Apost 2005 H

filed within 72 hours after Baltimore, Maryland 21215-0036 al Hygiene.

> attending ph signed by the a page 2 s has certificate this

Physician /Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: LUCAS : After this funeral of death. Director: within 24 hours a

To the Funeral C State Registrar

1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Albert Benjamin Lucas, Sr. 0205 AM 2005 October /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Balhmore
If Under 1 Year If Under 24 Hrs. n/a Saint Agnes Hospital 8. Date of Birth (Month, Day, Ye 6. Sex 1 XM 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 87 Vrs Jan 8, 1918 Maryland 220-01-1899 Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ehow in then "natural", or itema 23a or 28a-f ehov The Madical Exemilier must be natified at 1 ☐ Yes 2 ☑ No Baltimore Baltimore Director Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 5422 Clifton Avenue #W00 21207 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Sophie Harvey Joseph A. Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1952 Ormand Road, Dundalk, Maryland 21222-4622 Ronald Ridings / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland 10/17/05 Woodlawn Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature o Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Due to (or as a consequence of): Left month em pyema pneumonia Sequentially list conditions, if any, reading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mohammed MD 917601 October 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

Balhmore,

MD

900 S. Caton Ave

32. Registrar's Signature

Mohammed

OCT 1 3 2005

Nareesa

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Joshua Lloyd Lawrence October 2005 8:45p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1006 Turney Avenue Prince Georges Laurel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₩ M 2 □ F Director Yrs 216-18-3563 83 March 4, 1922 Maryland Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or iteme 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo Maryland Prince Georges 1 ☐ Yes 2 ☐ No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Turney Avenue 20707 United States America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Evantinat once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communication Engineer Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard T. Lloyd Harriet Lockwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Gary Street Cheney, Susan Pinault/Daughter Washington 99004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Gremation 3 Removal from State Meadowridge Mem. Park 10/06/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility low Fleck Funeral Home 7601 Sandy Spring Road Laurel, 8 Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrythmia **Physician** Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 10years Due to (or as a consequence of): Examine certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Atrial Fibillation Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 ☐ Yes 2 X No 1 Yes 2[] No or Attending Physician: effer death. Director: After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Certification: 28h Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel o within 24 hours eff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD October 4, 2005 D22755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Delima, MD 7350 Van Dusan Road; Suite 260 Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 3 2005 Registrar

		1 - For State Registrar		of Ma	ryland /	Depa Cer	artme rtifica	nt of H te of L	ealth a Death	ind M		Reg. No.	2005		3089
Physic /Medi		Decedent's Name (First, Middle, Jean	Last) Marie		LTe	ewell	yn				2. Date of De Month October	Day	2005 Year		e of Death
Exami	ner				(In yrs. last b		Silv If Unde	r, Town, or er Spr er 1 Year Days	ing If Under 2	24 Hrs.	8. Date of Bir (Month, Da	th		`у	ite or Foreign
Director		162-24-0985 Usual Residence of Decedent	1 M 200 F		74	Yrs.		l			Nov. 19,	1930	Per	nsyĺvan	ia
death with the Maryland ms 23s or 28s-f ehow	2	10a. Slate 10b. County			10c. City, To	wn or La	cation								e City Limits Yes 2 ☐ No
h the h	Director	Maryland Prince 10e. Street and Number	Georges		Laurel		10f. Z	ip Code				10g. Citi	izen of What (^	
ath will		8807 0xwell Lane							708				d States		
d within 72 hours after death with the Marylan Iten "naturel", or items 23s or 28s-1 ehow Ite Medical Examiner nast be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marne 3 Widowed 4 Divorced	12. Was Dec Armed F d 1 ☐ Yes If Yes, G Year or I	orces? 2 ∐ No ive X			Was Dec If Yes, sp		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify: Wh	nite, etc.	٦,
within 72 hours after ene. then "nature!, or ite	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)				(Give	kind of w	use retired	lurina most	of workii			nd of Busines	s/Industry	
e filed other	e e	17. Father's Name (First, Middle, L John J. Shouli							18. Mothe		(First, Middle	, Maiden	Sumame)		
ind 2 should bath and Ment 127 is marked or traumatic o		19a. Informant's Name/Relationsh Neil Llewellyn / H					ng Addres				A Route Numb			, Zip Code)	
permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked ery injury or other traumatic ery injury or other traumatic appg.		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	20b. Place cemet				t t	0/12/	2005		nsville		
permit. Departr imports eny inje		21. Signature of Fineral Service L	censee Mus							-	ck Funer aurel, M	al Ho	me		
Physician be executed by sician and burial-transit s the burial-transit	ai Examiner	shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to an reducte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Con Due to Me to Due to	gesti (or as a a stat (ur as a	ve Hear consequence consequence consequence	e of): ian C								Onset a	Belween and Death
death certifica e attending phi id for use as th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 3√□ No 9 □ Unknown		birth 2 nant at t	of pregnancy 2 Petal deal ime of death		⊒Ectopic ⊒ Other (s	oregnancy specify)					23d. Date of d Month	elivery Day	Year
iaw requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	s contributing to	death but	t not resulting	in the u	inderlying	cause give	an in Part I.				use contribute		
The ete h page	Completed												prior to death?	autopsy finda completion as 2 \(\square\) No	ngs available of cause of
sician certifi irector	o Be	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital:	Inpatien	nt 2 ER/0	Sutmation	nt 3 🗆 🖸	Cthe)r		(Check only		2 (Coth / Co	- 6.1	
Attending Physical death	ation: To	27. Manner of Death 1 XNatural 5 Pending 2 Accident investig.	28a. Date (Mo			Time o Injury		28c. Injun Work	41110	2	me 5 Resi 28d. Describe			өспу)	
To the Hospital or Attending Physician: within 24 hours affer death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 288. Flac	ding, etc.	ry - At home, . (Specify)						28f. Location (City or To	wn, State			Vumber,
To the Hosp within 24 hou To the Funer completely file	Medical	(Check only 2 Medical 8 one)	Physician: To the xaminer: On the and ma	basis of conner slat	examination a	ge, deat and/or in	vestigatio	n, in my o	oinion, deat	d place, a th occurre	and due to the ed at the time,	date and	place, and du	ue to the cau	
To To	-	29b. Signature and title of certifier	2) V4	quati.		ļ	9c. License D62938					te signed (Moi	nin, Day, Yea	Mr)
10		30. Name and address of person v					Print)	A	1:	L 047	01				
	ate trar	Jessica Naught, MD 31. Date filed (Month, Day, Year) OCT 1 3	32.	Redstra	AVe.	_	Court		olis, M	ia 214	01				

CT05-06827 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amy Molinare-Dupree
State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

1- For Unpend Item 23a, 27, 28a-f. per me G848 10-20-05 tas Certificate of Death 10-25-05 takeg. No. 33090 1. Decedent's Name (First, Middle, Last) Amy Jean Molinaro-Dupree
Amy Molinaro-Dupree 2. Date of Death Month 3. Time of Death Year Physician. 7, 200 4c. County of Death October 0 5:04 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7214 Holabird Avenue Apartment B Dundalk Baltimore 8. Date of Birth (Month, Pay, Year)
JUL 7, 1965 if Under 1 Year Months Days If Under 24 Hrs. 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F Months Hours 214-94-7055 40 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Directo Maryland Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7214 Holabird Avenue 21222 IISA 238 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 6 White Specify: 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Robert A. Linsebigler Inez J. Speelman is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 st ,t Health ar / Item 27 tr Inez J. Linsebigler/mother 1 Brett Court Apt. 216 Essex, MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/11/05 Baltimore MD 21. Signature of Funeral Service Lieenses ²² Clame and Address of Facility
Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Narcotic intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualte for as a nonsecuanna of: Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, certiticate has been signi rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 XYes 2 No Yes : After this certifics funeral director, Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence MOther (Specify) Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury 10-(Mpnt 05ay Year) 28b. Time of **4:59**ry 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No found a M investigation 2 Accident found Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home 28f. Location (Street and Augustes or Rural Route Number Ave. City or Town, State) /214 Holabird Ave. tilled in by 4 Homicide ō apt.B, Dundalk, Maryland To the Hospital within 24 hours a To the Funeral I completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME October 7, 2005

Registrar

DHMH 17 Rev 1/2001

State

Greenberg

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Lillie B. McKnight 10:00 p 10 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sandtown Future Care Balto N/A 8. Date of Birth (Month, Day, Year) 8-10-1914 Birthplace (State or Foreign Country) Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 💢 F 073-16-6986 Yrs S.C. Director 91 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r 28e-f show 1X Yes 2 ☐ No N/A Balto Md Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or iteme 23a or Examiner must be 1000 N. Gilmore Street USA 21217 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes Z No Baltimore, Maryland 21215-0036 Specify: Black Specify: 3 ☐Widowed 4 ☐ Divorced δ "natural", tal Hygiene. d other then "nature event, I''s Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home N/A 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event 9008. 17. Father's Name (First, Middle, Last) Amanda Ragin Ludie Ragin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Saxon Valley Circle N. E. Atlanta, Ga 30319 Karen Duyon - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-2005 Taw-Caw Baptist Ch Summerton, S.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licensee, West 4300 Wabash Avenue Balto, Md 21215 of 1. Enter the disease, or complications that caused, he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athero Sebestie **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as tha burial-transit or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as tha burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 🗖 Onknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has t irector, paga 2 s 1□ Yes 2□ No After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Medical Certification; To 1 Yes 2 No 4\\ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours aftar death.

To the Funeral Director: Af
completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D17537 a) (Type, Print) 1600 W. MOUNT Royal Ave Balto 21217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SALUJA DARSHAW. 31. Date liled (Month, Day, Year) 32. Registar's Signature State 2005 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year October 12 2005 0130 line 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death existence for k St. Mary S If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Feb. 35, 1932 Georgia 5. Social Security Number entes Care If Under 1 7. Age (In yrs. last birthday) 1□ M 2√F 212-26-3509 Yrs. Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits St. Mary's Lexington 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? US:A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working pite. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tom Riggins Elsie Hayes 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latham - great 13004 Iroquois Way Lusby, ms 20657 nephew 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Methed of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-19-05 Lansdowne, MD Zion Cemeters 4 ☐ Donation / ☐ Other (Specify) 21. Signature of Fineral Service Ligens 22. Name and Address of Facility Bary P. March Flit 270 Fredhilton Pass Batto mo 21229 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tree. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury in a limit lead section). Due to (or as a consequence of): Due to (or as a consequence of). resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗓 🕽 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of De 1 ☐Natural 2 ☐ Accident 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

Examiner ettending physician and I for use as the burial-transit Physician/Medical ete has been signed by the e page 2 should be deteched f P.0. of Vital Records, þ Completed Be 70 After this within 24 hours effer death.

To the Funeral Director: After thi completely filled in by the funeral Certification:

Division

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

show

7 is marked other then "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be multified at

and Mental Hygiene.

Pages 1 and 2 nent of Health an nt: if item 27 is 1 y or other

Physician

/Medical Examiner

Saltimore, Maryland 21215-0020

3 ☐ Suicide

29a. Certifier

4 Homicide

28c. Injury at Work? 1 Tyes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of

6 Could not be

OCT 1.3 2005

29c. License number 19917 29d. Date signed (Month, Day, Yeer)

we and address of person who complet d cause of death (Item 23a) (Type, Print)

Bayside Care C

State Registrar

Medical

DHMH 16 Rev 6/95

Physic /Medi Exami **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "netural", or Itams 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be natified at once.

mc EWR

Amalia

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, D

	Please T		., ack Indelible Ink. Ensure		
	1 - For State Registrar	State of Maryland	/ Department of Health an Certificate of Death	d Mental Hygier	2000 00004
an	Decedent's Name (First, Middle, Last)	Amalia	- McT-wen	2. Date of Death	Day Year 3. Time of Death
er	4a. Facility Name (If not institution, give s	Street and number) Nursing Co	enter Balty		4c. County of Death n/a
	5. Social Security Number 081-09-2846 Usual Residence of Decedent	7. Age (In yrs. last		Hrs. 8. Date of Birth (Month, Day, Yea	
tor	10a. State 10b. County		own or Location		10d. Inside City Limits 1
al Direc	Maryland n/a 10e. Street and Number 3320 Benson Aver		Baltimore 10f. Zip Code 21227	100	Citizen of What Country?
by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	Kind of Business/Industry
To Be Co	17. Father's Name (First, Middle, Last) Anthony Piscite			er Name (First, Middle, Maide a Schiano	insurance en Sumame)
	19a. Informant's Name/Relationship (Type Valerie A. McEwe	en - daughter	9b. Mailing Address (Street and Number of 22 Windbluff Court,		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State ceme		/11/2005 Ba	Location - City or Town, State
	21. Signature of Funeral Service License	ink	22. Name and Address of Facility F 4107 Wilkens Aver	nue, Baltimor	
	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	bations that caused the death. De cause on each line. Due to (or as a consequence	on not enter the mode of dying, such as care	siac or respiratory arrest,	Approximate Interval Between Onset and Death V L AV J
mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ementia		Years
	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):		
Be Completed by Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year
ed by Ph	Part II Other significant conditions conf	ributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Complet				24a. Was an autopsy performat? 1 □ Yes 2 □ N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Be	25. Was case referred to medical examiner?	ospital:		eath (Check only one)	
tlon: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing D. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 28d. Describe how inju	
Medical Certification; To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street a City or Town, Stat	ind Number or Rural Route Number, te)
edical (29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination a and manner stated.	ige, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ice, and due to the cause(securred at the time, date an	s) and manner as stated. Ind place, and due to the cause(s)
Σ	29b. Signature and title of certifier	momo	29c. License number	91 Oct	ate signed (Month, Day, Year)
	30. Name and address of person who con	& Benson F	tuenue, Balt	timore N	lary and 21227
e ar	31. Date filed Month, Day, Year) OCT 1 3 2005	2. Registrar's Signature	Goods		1

DHMH 17 Rev 1/2001

Sta Registr

			For	State o	f Marylaı					and M	ental Hy	gienę	300	· ·	0000) [=
		_	State Registrar			Ce	rtificate	of [Death			Reg. Né	200	J	3309	15
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	/Medic	al	4a. Facility Name (If not institution, gir	ro etropt and nu	mher)		4b. City, To	own or	Location o	of Death	10/10/		County of	Dooth	4:30P	М
,	Examin	er	8046 Kavanaugh R		moer)		Dunda.		Location o	n Deau			altim			
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs	last birthday)	If Under 1	Year	If Under 2		8. Date of Bir (Month, Da				lace (State or Fo	oreign
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	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City L	imits
	Maryli f sho	ō	Maryland Baltimo	re		dalk									1 □ Yes 2	
	r 28a	Irec	10e. Street and Number				10f. Zip C	ode				10g. Cit	izen of Wh	at Cour	try?	
	th with	Funeral Director	8046 Kavanaugh Ro	ad			212	22				Trin	nidad			
	r dea	ner	11. Marital Status	Armed Fo	edent Ever in U prcęs?,	J.S. 13.	Was Deceder	nt of His	spanic Orig	gin? (Spe , Puerto l	cify Yes or No Rican, etc.))-	14. Race - Black.	Americ White,		
3	s afte	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir Year or D	2 No ve		1 ☐ Yes 2	. /	Specify:						Indian	1
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<u></u>	C C - 0		19a. Informant's Name/Relationship Marlon Mohammed								Route Numb					
	Health tem 27 other tr		20a. Method of Disposition		20b.	Place of Dispo					ate		cation - C			
ē	Pages nent of int: if it		1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec	Removal from	State	cemetery, cre yview (10/14	1/2005	Balt	imore	- M	aryland	
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Division of Vital Records,	ol or Attending P after death. I Director: After t d in by the funera	Iffice	3 ☐ Suicide 6 ☐ Could not determine	289. Place	e of Injury - At i	nome, farm, st	reet, factory,	office		2	28f. Location (or Rura	l Route Number	í
ā	tel or A rs after el Direc ed in by	Certification:	4 - Homicado	Build	ing, etc. (Spec						City of 10	wn, State	"			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification of the funeral director, completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P	miner: On the b	pasis of examin	owledge, deal ation and/or in	th occurred at	t the tim n my op	ie, date and pinion, deat	d place, a th occurre	and due to the	cause(s date and	and manr d place, an	er as st	ated. the cause(s)	
	ithin 2 the of the omple	Med	one) 29b. Signature and title of certifier	and man	iner stated.		29c.	License	number			29d. Da	te signed (Month.	Dav. Year)	
l	6 4 5 4			S. NAJJA	AR MD		D	005	0566				/11/05			
	0		30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type				-	Ai:					
_	8		30. Name and address of person who	4540 East	tan Aven	ve Divis	of G	endial	37 AL	E Ba	Monne	MISZ	1664			
	Sta		31. Date filed (Month, Day, Year)	32. F	legistrar's Sign	iature										
	📡 Registi	all	OCT 1 3	2005	10.0	K	Carle .	,								

DHMH 17 Rev 1/2001

State Registrar 22 SOUTH GREEVE STREET BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2005

. Registrar's Signature

KATHERING L METZ MD

31. Date filed (Month, Day, Year)

		State State Registrar Amend Item 29c, Decedent's Name (First, Middle, Last)	- per br.,00		2. Date of Dea	ith	3. Time of Death
Physicia /Medic			Ann	Middleton	Septem		
Examin Funeral Director	er	4a. Facility Name (If not institution, give street and Bullimore Washington 15. Social Security Number 6. Sex 1 M 2 13-32-1975	Vedical Cent	9-11-0	PA Hrs. 8. Date of Birth Min. (Month, Day	4c. County of Death Anne A (Year) 9. Birth Cou 1934 Mary	place (State or Fore
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	or Location			10d. Inside City Lim
Mary a-f sh	tor	Maryland Anne Arundel	Glen Bu	urnie			1 √Yes 2 □
death with the Maryland me 23a or 28a-f show must be notified at	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
leath v	Funeral	413 We11ham Ave	Decedent Ever in U.S.	21061 13. Was Decedent of Hispanic Original Control Original Contro	in? (Specify Yes or No-	USA 14. Race - Amer	ican Indian,
ours after or rail, or item	by	1 Never Married 2 Married 1 Yes	iForces? es 2∰No	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	Puèrto Rican, etc.)		, etc. nite
mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan satiment of health and Mental Hygiene. Satisfact of the marylan and Mental Hygiene. The content: If the maryla marked other than "natural; or treme 23a or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at its judges.	Completed		ed) 16a. pe (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	16b. Kind of Business/li	
Hygie other	Be Co	17. Father's Name (First, Middle, Last)		Homemaker 18. Mother	r's Name (First, Middle,	Own Home Maiden Sumame)	
Menta Menta Brked atic ev	To B	Bernard Micha			thleen	Marie	Kelly
12 shound hand 7 is m	9	19a. Informant's Name/Relationship (Type, Print) Brian M. Middleton (Son		Mailing Address (Street and Number 13 We11ham Ave.,			p Code)
s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or T	own, State
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Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	of Death (Check only or		
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To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical Ce	(Check only 2 Medical Examiner: On the	ne basis of examination and name stated.	29c. License number 29c. P45149	×	19d. Date signed (Month. September 2	Day, Year)

			For State Registrar	State of Ma		partment of Health ertificate of Deal		Hygiene	05	22000	
hy -	Physici /Medi		Decedent's Name (First, Middle	Alice	<i>N</i> .	Moos	2. Date of Month		Z005	9 25 AM	
728	Examir		4a. Facility Name (If not institution Brighton Gar 5. Social Security Number	dans Assisted	(In yrs. last birthd	av) If Under 1 Year If Und	ora der 24 Hrs. 8. Date o	H H	owal owal 9. Birthol		
	Funeral Director		198-07-1191 Usual Residence of Decedent	1□M 2×F	86 Yrs	Months Days Hour	rs Min. (Monti	h, Day, Year) Der 18, 1918		lace (State or Foreign try) New York Od. Inside City Limits	
20/1/01	the Marylar 28a-f ehow colilled at	ector	Maryland 10e. Street and Number	Howard	10c. City, Town or	Colum	nbia	10g Citizen	1 □ Yes 2 No		
?	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thysiene are seen then "natural", or Items 23a or 28a-f ehow ont, the Madical Exam our must be notified at	by Funeral Director	7108 Brandywine V	12. Was Decedent E	iver in U.S.		21046 Origin? (Specify Yes of ican, Puerto Rican, etc.		U.S. Race - America Black, White, e	A. an Indian,	
5	5-0036 72 hours afte natural, or It	ted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	0 16a. De	1 Yes 2 No Spec	cify:	Spe	cify:	White	
ALICE	Maryland 21215-0036 to 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Maulical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	- lif	ive kind of work done during no DO NOT use retired) Homem	aker		Own H	lome	
4	re, Maryland 2 s 1 and 2 should be filed t Health and Mentat Hyg ttem 27 is marked other other traumatic event, I	To Be	17. Father's Name (First, Middle, W 19a. Informant's Name/Relations	illiam Nicholl	19b. M	ailing Address (Street and Nur	other's Name (First, Manueleur) mber or Rural Route N	Millie Dau	ohin	Code)	
noos	of Hear		Ms. Holly Rot 20a. Method of Disposition 1 □ Burial 2 © Cremation	h Daugh	20b. Place of Di	7108 Brandywine V sposition (Name of crematory or other place)	Way Columbia,	4-4	046 in - City or To	wn, State	
E	Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		4 Donation 5 Other (S 21. Signature Juneral Service	pecify) Lîcensee	M00575	ayview Crematory 22. Name and Address of Fa Slack Funer	ral Home, P.A.	-	Baltimor	e, MD	
	Physician /Medical		23a. Part1. Enter the disease, or hock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	omplications that caused only one cause on each lin	the death. Do not	3871 Old Content the mode of dying, such	olumbia Pike El as cardiac or respirate	licott City; MI ory arrest,	21043	Approximate Interval Between Onset and Death 4 Years	
1/8	8760, atte be executed wax thysician and the burial-transit	dical Examiner									
	I Records, P.O. Box 65 The law requires that the death certifics ate has been signed by the attending phage 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of the Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			Date of delive Month	ory Day Year	
	cords, P. w requires that the been signed by should be detact	þ	Part II. Other significant condition	ons contributing to death bu	it not resulting in th	e underlying cause given in Pa		Did tobacco use c			
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	Sion of V stending Physic for: After this ce the funeral dire	ertification; To Be	25. Was case referred to medica examiner? 1	Hospital: 1 _ Inpatier 28a. Date of Injur (Month, Day)	y Yea <i>r)</i> 28b. Tim Inju	tient 3 DOA Other: 4 e of ry M 28c, Injury at Work? M 1 Yes 2	2 □No		curred	77	
	Divisi To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	O	4 ☐ Homicide determ 29a. Certifier 1 ★ Certifyin	ng Physician: To the best of	of my knowledge, d	street, factory, office	City of	or Town, State) the cause(s) and	manner as st	ated.	
	To the He within 24 To the Fu	Medical	(Check only one) 2 Medical 29b. Signature and title of certifie	and manner sta	ted.	29c. License numb	per	29d. Date sig	ned (Month, I	Day, Year)	
	\wedge		30. Name and address of person	who completed cause of de	eath (Item 23a) (Ty	pe, Print) Ridge Rd	Calumb	oia, w	1021	1044	
	St Regist	ate trar	31. Date filed (Month, Day Year)	3 2005 32. R sistra	r's Signature	Audi	, 00.0	7		-	

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1306 M **Physician** MEALS EDWARD 10 07 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner JOHNS HOPIUMS BAYVIEW MEDICAL CEMER BALTIMORE N/A 8. Date of Birth (Month, Day, Year, APRIL 27, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1₩ M 2□F 214-88-8831 Yrs. MD. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be nutitled at 1 √Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3616 MARY AVE. 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 11♥ Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify. WHITE Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NEVER WORKED NEVER WORKED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GERALDINE A. KLAPKA EDWARD P. MEALS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 830 BRUNSWICK RD., BALTIMORE, MARYLAND 21221 EDWARD P. MEALS/FATHER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 10/11/05 OAK LAWN CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, 21. Signature of Funeral Femus. Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear failure. List only one cause on each line. diate Cause (Final Airway Obstruction due to 2 h **Physician** disease or condition resulting in death) /Medical Examiner 23 Y returdation Cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit di3 order Attending Physician: The law requires that the death certificate be executed Suiture Due to (or as a consequence of): 23 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death MED 3232 Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 3 Probably 4 □Unknown 2 No 1 🗌 Yes Jorsk Completed CERTIFICATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No this certificate 1 🗌 Yes 2 ☑ No 26. Place of Death | Check only one Be 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ► FVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 12:27 M 2 Accident investigation 10/07/2005 SUBJECT CHORED ON FOOD s after death. 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ADULT DAY CARE 3616 MARY AVENUE To the Hospital within 24 hours a To the Funeral E (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number \$ 362 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Pathologist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BARROWER MD 21224 HONGXIU 31. Date filed (Month, Day, Year) QCT 1 3 Megistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of	Maryland	-	artmen					iene	2005	33	100
\ Physic		1. Decedent's Name (First, Midd Samuel Newton								2. Date of Dear Month Septemb	th Day	Year	3. Time o	of Death) PM
Exam		4a. Facility Name (If not institution		oer)		4b. City,	Town, or	Location of		•		ounty of Dea		
		Heartland of 5. Social Security Number		e Age (In yrs. lasi	ė finimais mas s s	Hya If Under		ille If Under	24 Hre	O Data of Dist			eorge's	
Funera Directo		227-34-0067 Usual Residence of Decedent	1 M 2 □ F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day)	Year)		thplace (State ountry) rginia	or Foreign
Maryland	tor	DC 10a. State 10b. County 10c. City, Town or Location Washington											10d. Inside C	City Limits
ith the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citize	en of What Co	ountry?	
ath w		3831 13th Stre						20011				USA		
goes 1 and 2 should be filed within 72 hours after death with the Maryland goes 1 and 22 should health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-1 show or other treumatic event, the Medical Examinar must be routiled at	by Funerai	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Divorced	It tes Give	es? □ No	1	Was Deced If Yes, spec 1☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spec n, Puerto P	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: 1		
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id 2 s ith an th an treu	1	Evelyn Day								Arling	-			
s 1 ar f Hea item		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	ne of	T				ation - City or		
Pages nent of nnt: If it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☑ Other (5	3 □Removal from Sta	ate	etery, crei	matory`or oi	ther place	9)						
permit. Pages 1 an Department of Heali Importent: If Item 2 any injury or other		21. Si nature e Funeral Service		geeter		Name and tate A		-		655 W.	Ba1t	imore	Street	
10		23a. Pant. Enter the disease of shock or heart failure. Lis	r complications that cau	sed the death. (est,		Approximat Interval Bet	
Physician		Immediate Cause (Final disease or condition		CUR	3101	RES	PIR	670	121	BRRI	725		Onset and	Death
/Medica Examine	-	resulting in death)	Due to (or	as a consequen	ice of):									
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that the de led by the a detached f	Phy	Part II. Other significant conditi	ons contributing to deal	th hut not resultin	on in the u	nderlying ca	allea olve	n in Part I		23e Did tob	acco use	a contribute to	the cause of c	death?
or Attending Physicien: The law requires tha after death. Director: After this certificate has been signed in by the funeral director, page 2 should be det	ted by		ay pertu	N510N				# I III F QL (L)			s 2			Unknown
ysicien: The law is certificate has b director, page 2 sk	Completed		DIBBET	ES M	ELL	<u>17US</u>				24a. Was adautops perform	ned3/	prior to death?	itopsy findings completion of c 2 \(\subseteq \text{No}	available ause of
Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital		-17		104			(Check only on				
Phys this or	2	1 Yes 2 No	28a. Date of		Outpatier b. Time o	nt 3□ DO		4 1		e 5 Reside			cify)	
ding h. After funer	tion	1 Natural 5 ☐ Pendi		Day Year)	Injury	M	8c. Injury Work 1 □ 1	.? ′es 2 □ l		8d. Describe ho	w injury	occurred		
To the Hospitel or Attending Ph within 24 hours atter death. To the Funerel Director, Alter th completely filled in by the funeral	Certification;	2 Accident invest 3 Suicide 6 Could 4 Homicide detern	not be	f Injury - At home , etc. <i>(Specify)</i>	e, farm, sti					8f. Location (St. City or Town		Number or Ru	ıral Route Num	nber,
To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edicai	29a. Certifier Certifyi (Check only one) Certifyi	ng Physician: To the be Examiner: On the bas and manne	is of examination	idge, deat and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, ar th occurred	nd due to the ca d at the time, da	use(s) a ate and p	nd manner as lace, and due	stated, to the cause(s	\$)
To the composition	Σ	29b. Signature and title of certifie	//			29c.	License	number		25	9d. Date	signed (Monti		
	1	• 4	aue a	er	MS		De	20 S	820	GF		16/4	105	
		30. Name and address of person				Print)			THE RESERVE	in the second			The state of the s	
		STR CSHKUMA	R MUTTA	117 420	30	<u>0661</u>	15 BL	1 RY	RD.	HYAS	TSV	ILLE,	MJ 5	0281
S Regis	tate	31. Date filed (Month, Day, Year	2005	istrar's Signature	dos	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ivia	тукана / Бера Сел	rtificate of l			g. No. O	
			Decedent's Name (First, Middle, Last)					2. Date of Deat	200	5 3. Time of the alp
	Physicia		Willian	r F. Obit	tz			October	Day Yea 11, 2005	7:00 A M
1	/Medic Examin		4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, or	Location of Deat		4c. County of De	
	EAGIIIII	٠.	557 Palisades Bo	ulevard		Crown	nsville		Anne A	rundel
	Funeral		Social Security Number 6. Sep. 3		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAR 30,	Year) 9. B	irthplace (State or Foreign Country)
	Director		218-32-6998	(M 2□ F	69 Yrs.	Worth Suys	110410	MAR 30,	1936 M	lary1and
	pug 3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation			10d. Inside City Limits	
	sho	5		Tobara						1 ☐ Yes 2 X No
	the A	Director	Maryland Anne Ar 10e. Street and Number	under		10f. Zip Code	wnsville		ng. Citizen of What (Country?
	with a or		557 Palisades Bo	11 orrord		210	122			bounty.
	leath	Funeral		12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	USA 14. Race - An	nerican Indian,
(0	r Iter	Fur	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give	0			o Rican, etc.)	Black, Wh	
8	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	955-59	1 ☐ Yes 2 📉 No	Specify:		Specify:	White
5	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show I.a M. Alcal Exabiter must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occupa	during most of wor	nkin a	16b. Kind of Busines	•
2	ithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	-) life.	DO NOT use retired	"		Departmen Defense	t of
2	lled v lygie her t		12 17. Father's Name (First, Middle, Last)		Ar	nalyst	18 Mother's Nar	ne (First, Middle, M		
anc	ntal hed of	Be		- G.,						
Ē	hould d Me mark matic	မ	William F. Obit 19a. Informant's Name/Relationship (Ty		19h Maili	ng Address (Street a		nadine So	Chlatzer City or Town, State,	Zin Code)
Maryland 21215-0036	d 2 s th an trau		Joan F. Obitz/Wi	• •		-			sville, M	
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City of	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury or other traumatic event, It w M. Jical Examination at the notified at ODGE.		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Metro Cre			1/05	Baltimo:	re MD
ij	mit. F partm ortar injur		21 Signature of Funeral Service-License	ee / /						
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused	the death. Do not ent	ter the mode of dying	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between
- K	Physician		Immediate Cause (Final disease or condition	io dados dir oddir iii.		laryno	001 (gnier		Onset and Death Seventeen
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		-	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of d	elivery
Box	that the death cer ed by the attendir detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		∃Ectopic pregnancy ∃ Other <i>(specify)</i>			Month	Day Year
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ord	w requir been si should				· · · · · · · · · · · · · · · · · · ·			1 ☐ Ye	s 2 □ No 3 □ F	Probably 4 Unknown
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<u> </u>		Con						perform 1 Yes 2	ed? death?	
/ita	icien: certifica rector, p	Be	25. Was case referred to medical examiner?	Januital.		24		ath (Check only one		
of Vital Records,	Physicien: this certific ral director,	P	1 162 5 140	lospital: 1 ☐ Inpatier					nce 6 Other (Sp	ecify)
n o	ar and	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	rat ⟨? Yes 2 □No	28d. Describe how	w injury occurred	
isic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry · At home, farm, str		163 2 1140	28f. Location (Str.	eet and Number or F	Rural Route Number,
Division	lor A after Direction by	ertification:	4 ☐ Homicide determined	building, etc.	(Specify)	oot, ractory, critica		City or Town,		
	spite nours neral	aic	29a. Certifier 1 Certifying Phys	sician: To the best o	my knowledge, deat	h occurred at the tim	e, date and place	, and due to the ca	use(s) and manner a	as stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination and/or in ed.	vestigation, in my op	oinion, death occu	rred at the time, da	te and place, and du	ue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	1		29c. License	number	- 1	d. Date signed (Mor	1 /
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1	9		30. Name and a ress of person who co	mpleted cause of de			11/40	22 1	he	MD2149
J			Kenn & Fno/	32. ⊋egistra	900 B	3759te	10 7750	U HI	mapolio,	MUGIY
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 3 201	15 January 15	is dignature	aste 1			V	

		•	For State Registrar	State of	f Marylar				lealth a Death	ind Me	ental Hyg	jiene leg. No	2005	33102
	,	'ge	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Antonie	Ann		Pauli	S				10-10-	-200s	5	11:10 A M
i.	Examin		4a. Facility Name (If not institution, g		nber)		4b. City		r Location o				County of Death	
			8235 Rupert Road 5. Social Security Number 6.		7. Age (In yrs.	last highday)	If Unde	Mil.	lersvi		8. Date of Birtl		ne Arund	
	Funeral Director		212-42-3001	1 □ M 2 🔼 F	62	Yrs.	Months	Days	Hours	Min.	(Month, Day 8-13-	Year)	9. Bittin Cour MD	place (State or Foreign ntry)
	D .		Usual Residence of Decedent											
	arylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	10d. Inside City Limits
	Ba-f s	octo	MD Anne Ar	undel	Mil	llersvi								1 ☐ Yes 2 ☒ No
	with ti	D.	10e. Street and Number	0				Code					en of What Coul	ntry?
	ns 23	Funerai Directoi	8235 Rupert Road		dent Ever in U	J.S. 13. V		108 dent of H	lispanic Orio	in? (Spec	cify Yes or No-	U.S.	A . 4. Race - Americ	can Indian,
0	r Iten	Fun	1 Never Married 2 Married	Armed For	rces? 2 🔀 No					Puèrto F	cify Yes or No- Rican, etc.)		Black, White,	etc.
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N	e filed within 7 al Hygiene. I other than "n vent, I'r e Mad		10 17. Father's Name (First, Middle, La	st)		Sola	erin	g	18. Mothe	r's Name	(First, Middle,		throp Gr Sumame)	umman
Maryland	d be ental ked o c eve	To Be	Amos Reidy	,						na No			,	
3	permit. Pages 1 and 2 should be 1 Department of Heath and Mental P Important: If item 27 Is marked or any injury or other traumatic eve once.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street				r, City or	Town, State, Zip	Code)
Ĕ	and 2 alth a 27 is	8 4	Sandra A. Lombar	do / Dau	ghter	315 M	ary1	and A	Ave; I	Pasad	ena, M	211	122	
9	of He of He liter	1	20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3	□ Ramoval from 5	20b. f	Place of Dispo cemetery, cren	sition (Na natory or	me of other plac	ce)	Da	ate	20c. Loc	ation - City or To	own, State
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	ly one cause on e	ach line.						4.556			Approximate Interval Between Onset and Death
	Pnysician /Medical	Ϋ́	Immediate Cause (Final disease or condition resulting in death)				G!	ts1/2	210	CA	LCI NO	DMC	+	
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Ó	eath certificate attending phys I for use as the	ĕ	IF FEMALE:	220 If you out	nama of arasa	2004								
X R R	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 ∏Feta ant at time of o	al death 3 □	Ectopic p		,			23	3d. Date of delive Month	ery Day Year
o.	at the de by the a	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		Jouin 5	J Other (s	Journy)						
3 _	g g g		Part II. Other significant conditions	s contributing to de	ath but not res	sulting in the ur	nderlying	cause giv	en in Part I.		23e. Did to	bacco us	e contribute to the	he cause of death?
ecords,	w requires to been signed should be	ed by									1 🗆 Y	es 2.□	No 3 Prob	oably 4 DUnknown
O O	s bee	olete									24a. Was a	an	24b. Were auto	psy findings available
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Vital R	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			
o 	Physic this ce al dire	2	1 ☐ Yes 2 No			ER/Outpatien			4 🗀 1901				□Other (Specif	y)
Ē	ding P h. After t funera	inol	27. Manner of Death 1 SNatural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury		28c. Injun Worl			8d. Describe h	ow injury	occurred	
Division	uttendi death. ctor: A y the fu	Certification:	2 Accident investigat 3 Suicide 6 Could not	be 390 Blace	of Injury - At h	omo form etc	M		Yes 2 1		9f Location /S	treet and	Number or Rum	Il Route Number,
2	after d	ertif	4 ☐ Homicide determine	buildii	ng, etc. (Speci	fy)	eel, lauto	y, omce			City or Tow		TVBITIDOS OF TIBIO	i Hobie Hamber,
	spital lours neraf		29a. Certifier 1 Certifying	Physician: To the	best of my kno	owledge, death	occured	at the tin	ne, date and	d place, a	nd due to the o	ause(s) a	and manner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Ex	aminer: On the ba	asis of examination of the stated.	ation and/or inv	vestigation	i, in my o	pinion, deat	h occurre	d at the time, o	late and	place, and due to	the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		,		29		e number				signed (Month,	
			> = (CP 0	ode_	_ /4	0		D	217	76	C	ST X	BELL	r' 5002
	.2		30. Name and address of person wh	no completed caus	e of death (Iter		Print)	(Hari	OUG	X 57	. ,	CACT!	MORK
	10		31. Date filed (Month, Day, Year)	O NUM	A M egistrar's Signa		50(، د			(7	, -11	
	Sta Registi		OCT 1 3 20	6	7.4	Span	w							

			For	State of Marylan				Mental Hy	giene	00100
争		ðs.	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of	Death	2. Date of Dea	Reg. NZ UU5	3 3 U 3 3. Time of Death
	Physici /Medic		Vicainia	Prichard				Month	Day Year	0 119 1011
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea		4c. County of Dea	
And		25 .	5. Social Security Number 6. Se	Sp. Jal	last hirthday)	Bai+	If Under 24 Hrs	B. Date of Birth	1 Bal	timore City
	- Funeral Director			M 20 F	Yrs.	Months Days	Hours Min	(Month, Day	r, rear)	rthplace (State or Foreign \ Country) Ohio
	pue A		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation			03,1143	10d. Inside City Limits
	Maryli -1 sho	to	D		Baltimo					1 ☐ Yes 2 🎛 No
	th the or 28a e notif	lrec	10e. Street and Number			10f. Zip Code	-		10g. Citizen of What C	ountry?
	72 hours after death with the Maryland natural', or teme 23a or 28a-1 show draf Exember mut be motified at	Funeral Director	3181 Freeway R				227		U.S.	
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
21215-0036	ours a	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: Wh	nite
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of wo	nking	16b. Kind of Business	s/Industry
212	f within piene. r than "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook	O NOT use reared	D)		Restaur	ant
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other treumatic event, the Madical Examinar must be notified at		Betty Feeheley /			eagull Di			r, City or Town, State, Maryland	
ore,	es 1 a of Hez fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F		lace of Disposemetery, crem	sition (Name of latory or other place	ce)	Date	20c. Location - City o	r Town, State
Baltimore,	thent of it	19	4 □ Donation 5 □ Other (Specify)	Ba		rematory		., =	Baltimore,	
Bal	permit. Pages Department of Importent: If It any Injury or o		21. Signature of Funeral Service Licens		// .	Name and Addre			eral Servi	
*	· • • •		23a. Part1. Enter the disease, or corp shock, or heart failure. List only o	lications that caused the deat						yland 21225 Approximate
	Physician		Immediate Cause (Final disease or condition	ne cause on each line.	10000					Interval Between Onset and Death
粉	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					12 (10)4/13
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8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
687	tificate I g physi as the b	edicai		d						
Вох	dir idir	M/W	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of de	livery
О. В	the attenthed for u	by Physician/Med	in the past 12 menths? 1 □ Yes = 2 ØNo 9 □ Unknown	4 Pregnant at time of d		Other (specify)			Month	Day Year
σ.	res that the de igned by the a be detached f	Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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<u> </u>	Physicien: this certificantal director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	EB/Outpatient	3 DOA Oth		ath Check only on	ele. ence 6 ⊡Other (Spe	no.fel
Division of Vital Record	ng Phy fter thi ineral		27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun			ow injury occurred	eny)
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	200 Bloom of Animal At he		M 1 🗆	Yes 2 □No	004		
Σ	al or A after i Direc d in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/)	et, ractory, office		City or Town	reet and Number or R n, State)	ural Houte Number,
	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wiedge, death	occurred at the tin	ne, date and place	e, and due to the co	ause(s) and manner a	s stated.
	thin 24 the F or the F	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licensi				
)	£ ₹ ₹ 8		De la comina	A. III	W)	DF			9d. Date signed (Mon	,
	١		30 Name and address of person who a	ompleted cause of death (Item	23a) (Type, f	Print)			MODET (08,2005 in 21005
	\		31. Date filed (Month, Day, Year)	32. Remistrar's Signa	3001	Such	Hanor	er Stree	L Balding	6 HD 21025
	Sta Registr		OCT 1 3 2		H A	raeli)				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Raymond H. Pirtle October 10 2005 3:00 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 824 Bentwillow Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 2, 19 **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F Yrs. Director 412 66 3217 61 1943 Tennessee Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event. Its Mudical Examinativust for modified at Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 Bentwillow Drive 21061 U.S. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Viet Nam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver 6th Giant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Jesse Pirtle Mary Tate Greggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Jean Pirtle / wife 824 Bentwillow Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crownsvile, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem 10/13/2005 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced HYDOXIU EOPA 20 years disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No į 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð HOM 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DW 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2 No 2[] No 1 ☐ Yes 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5, Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 H17744 10/10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Hospital Drive Suite 215 Glen Burnie, Maryland 21061 Dr. David Schwartz State Blown & A Registrar

			For State Registrar	State of M		epartment o Dertificate o	f Health and North		giene 200	5	33105
· ·	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	er 7 200	Year	3. Time of Death
	/Medic Examir		Audrey J. Pino 4a. Facility Name (If not institution, give)	4b. City, Tow	n, or Location of Death	<u> </u>	4c. County	of Death	10:24a M
	- X-	X. F	GREATER BALTIMOR 5. Social Security Number 6. 9		CENTER	TOWSON		8. Date of Birth	BALTI		
\geq	Funeral Director	V		1 □ M 2 ₩ F	80 Y	Months Da		Dec 14,	r, Year)		place (State or Foreign htry) 1and
RE	and land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
P	be filed within 72 hours after death with the Maryland half Hygjene. Ind other then "naturel", or itema 23s or 28s-f show event, tra Madical Examinar must be notified at	ctor	MD		Balt	timore					1√ Yes 2 No
75	with the	Dire	10e. Street and Number			10f. Zip Coo			10g. Citizen of W		ntry?
7	ma 234	erai	1011 Wheeler Ave	12. Was Decedent	Ever in U.S.		21216 of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race	e - Americ	can Indian,
HES, AUDREY	or ite	by Funeral Director	1 Never Married 2 Married	Armed Forces: 1 ☐ Yes 2 🕅 If Yes, Give		If Yes, specify (Hican, etc.)	Specify:	k, White, : b1	etc. .ack
Top	2 hours	ted b	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dates: ducation	16a. D	ecedent's Usual Oc	cupation		16b. Kind of Bu	siness/In	dustry
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# T D	filed withi Hygiene. other ther	e Col	17. Father's Name (First, Middle, Last	<u>5+</u>	r	eading sp	ecialist 18. Mother's Nam	ne (First, Middle,	educat: Maiden Sumami		
lan	should be ind Mental marked o	To Be	Charles William	Jones Si	c		Eliza	Harriet	Morsell		
Man	12 sho h and l 7 ie ma rauma		19a. Informant's Name/Relationship				eet and Number or Ru			State, Zip	Code)
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₹	0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Speci		Cometery,	crematory or ourer	piace				
A HE	permit. Par Departmen Important: eny injury		21. Signature of Funeral Service lice Ronald	Wash Div	extor	22. Name and Ac State And Baltimore	dress of Facility atomy Board e, MD 2120		Baltimo	re S	treet
4			23a. Pant. Enter the disease, or com shock or heart failure. List only	plications that cause one cause on each I	d the death. Do no ine.	t enter the mode of			rest,		Approximate Interval Between Onset and Death
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8760,	cate be ex physician the burial	dical		d						-	
Box 6	ath certifica attending ph for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delive	ery
. B	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death it time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify			Mon	th	Day Year
P.O.	res that the designed by the	y Phy	Part II. Other significant conditions	contributing to death t	out not resulting in t	he underlying cause	given in Part I.	23e. Did to	bacco use contri	ibute to th	ne cause of death?
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lecc	e law re has be ge 2 sho	Completed	obesity					24a. Was a autops	sy p	rior to cor	psy findings available mpletion of cause of
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Division	Attending Physician: r death. ector: After this certific: by the funeral director.	Certification:	2 Accident investigated 3 Suicide 6 Could not to	28e. Place of In	jury - At home, farn	n, street, factory, off			treet and Number	er or Rura	d Route Number,
Ö	ital or irs afte rel Dire		4 Hornicide	bullding, e	tc. (Specify)			City or Tow			
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fa	Me	29b. Signature and title of certifier	2/1			ense number	2	29d. Date signed		
			1 = 1/1	606	d		38712		10 -	7-	3002
			30. Name and address objectson who	Completed cause of	6 VILK	Road	Luthervi	The mi	210	193	
-	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 3 2005	26	rar's Signature	. N a					
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STEPHEN ROBINSON Unknown 05-06875

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	\$ 1 mar.		Registrar 1. Decedent's Name	e (First, Middle	e, Last)				7111100		Douth	2. Date of		. No.		3. Time o	of Death
	Physicia		STEPHEN	W.	ROP	BINSON						Octol		09	2005	7:56	ΔМ
	/Medic Examin	100	4a. Facility Name (III						4b. Cit	, Town, o	or Location of De				y of Death	7.50	11
	LAGITAT	A,	4500 Bloc	k N. F	rank	lintown :	Road			Baltimore N/A							
Г	Funeral	4	5. Social Security No	umber	6. Sex	7. Age	e (In yrs.	last birthday,	If Und	er 1 Year Days	If Under 24 H	n. 8. Date of	of Birth h, Day, Ye	ear)	9. Birthp Coun	lace (State	or Foreign
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	and		Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or L	ocation						1	0d. Inside C	City Limits
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	r 28a	Director	10e. Street and Nun		1			,,,,,,		ip Code			10g	. Citizen of	What Cour	try?	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do that than "natural", or iteme 23a or 28a-f show avent, the Mcdiral Examiner must be notified a	alD	4103 CH1	ESTER	FIEL	D AVEN	JUE			2121	3				USA		
	- He	Funeral	11. Marital Status		1	2. Was Decedent I Armed Forces?	Ever in U	.S. 13.	Was Dec	edent of h	Hispanic Origin? an, Mexican, Pue	(Specify Yes o	or No-		ce - Americ		
0	or It	by Fu	1 Never Marri			1 X Yes 2 ☐ N If Yes, Give	No.		1 🗆 Yes		Specify:		,				
Ś	hours ural',		3 Widowed			Year or Dates:		16- 8		-10			10		b BLA		
2	in 72	Completed		15. Deceden ify only highes		completed)		16a. Dece (Give life.	kind of v DO NOT	rork done	during most of w	vorking	161	D. NING OF E	Business/Ind	ustry	
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2	and N		19a. Informant's Na						3		and Number or i		_	,		Code)	
Ξ.	and 2 ealth n 27		PATRICIA		USC	M (WIF					RFIELD		BALI	0. M	D 21:	213	
פ	If ital		20a. Method of Disp 1 Burial 2 [3 □Re	emoval from State	- 0	Place of Disposemetery, cre	matory of	other pla	ما ا	Date	200	c. Location	- City or 10		
allino	ment tant: jury		4 Donation	5 Other (S	pecify)		_GA	RRISON				119/1	BOY	uing	8 MII	18, r	MD_
20	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If itam 27 is marked other than any injury or other traumatic avent, the Money.		21. Signfature of Fu	<i>y</i>	License	7		V	augh	NC.	ess of Facility GREENE	FUNER	ZAL S	SERVIC	E		
	du z e d	-	23a. Part1. Enter the	\	- Annalis		the dead	5	15 B	AUTO	NATU P	KE, B	AUTO.	MD	21229	Approxima	***
	*		shock, or hear	rt failure. List	only on	e cause on each lir	10.			_ :						Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (disease or condition resulting in death)	n n	a	Gans			ASC.	2) to	o Head	and	1300	CK			
	Examiner					Due to (or as	a conseq	uence of);							į		
L		e	Sequentially list con if any, leading to im- cause. Enter Unde	nditions, imediate	b .	Due to (or as	a conseq	uence of):									
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0/0	ysicie	dlcal			d												
	ng ph	0	IF FEMALE:		T .										.		
200	ath ce itendi	an/I	23b. Was decedent in the past 12		23	3c. If yes, outcome 1 ☐ Live birth			⊒Ectopic	pregnanc	у				ate of delive		Year
5	the a	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No		4□Pregnant at 9□Unknown	time of d	leath 5[Other (specify) _			_		Ontri	Day	1 641
Ŀ	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as		Part II. Other signif	_	ons con	tributing to death by	ut not res	ulting in the I	ınderlyind	Cause di	ven in Part I	23e.	Did tobac	co use cor	tribute to th	e cause of	death?
, S	signe d be	d b				g to cooking		2g	211001171119	ondoo ga	Contract City.		1 ☐ Yes	2 No	3 ☐ Prob		Unknown
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VII.		o Be	25. Was case reference examiner?			ospital:	ent 2 🗆	ER/Outpatie	nt 201	Ott	26. Place of D	eath <i>Check</i> c		- e Mo	has /C/	ato	ecene
5	ding Phys h. After this tuneral di	\vdash	27. Manner of Death	h		28a. Date of Inju	ry	28b. Time o	of	28c. Inju	ry at			injury occu		, at .	CCIIC
SION	Attending r death. ector: Afte by the fune	atlo	1 □ Natural 2 □ Accident	5 Pendir investi		Found, Day	05	Volume	AM	₩o 1 [Yes 2 No	50	ulsie	cts	MAT		
<u> </u>	Attences death	IIIC	3 ☐ Suicide 4 ☑ Homicide	6 Could determ		28e. Place of Injubulding, etc	ury - At h	ome, farm, st		ory, office		28f Locati	ion (Strac	at and Num	har or Rum	Route Nun	nber,
5	rs afti al Dir ed in	Certification:	7			Danding, etc	. Jopen	Park				N. Fr	anklin	TOWN	00 B4	altin	wemi
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	<u>e</u>	29a. Certifier (Check only	1 ☐ Certifyir 2 ☐ Medical	g Phys Examin	ician: To the best er: On the basis of	of my kno	wledge, deal	th occurre	d at the ti	me, date and pla	ce, and due to	the caus	se(s) and m	anner as st	ated.	s)
	To the H within 24 To the F complete	Medic	one)	Λ	_	and manner sta	ited.		-			2.0.0	-				- 1
	0 = 0 5	~	29b. Signature and	ririe or ceutile					2	SC. LICENS	se number		290.	. Date signi	ed (Month, I	Jey, rear)	

State Registrar CAROL H AUAW Md
31. Date filed (Month, Day, Year) 32, Jegi

OCT 1 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

October 10, 2005

Rick Robinson Amend Unpend item#1,23a,PII,2/,perME,G849,II-29-05 TT State of Maryland / Department of Health and Mental Hygiene 05-6787 KG 1 - For State Registrar Reg. No. 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 5, 2005^{ear} **Physician** 2:02 P Rickey Doyle Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Apt 808 Pasadena 8102 Pineberry Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 TN 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) XXM 2□F Days January27, 1950 Director 415-78-0235 55 Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any highry or other treumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8102 Pineberry Court #808 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

**EXYES 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽÍXNo If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Co Consulting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doyle Elwood Robinson Charslee Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Beretta 31 Vernon St, East Weymouth, Mass 02189 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Coremation 3 ☐ Removal from State Bavview Crematory 10-11-05 Balto., MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Representation (Specify)

R. Gregory Piak Fink Funeral Home, P.A. 426 Crain Hwy Sw, Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hoepital or Attending Physicien: The law requires that the death certificate be executed
 A hours effect death
 Funeral Director; Affer this carrificate has have already the the control of t ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? à Post-Traumatic Stress Disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of de th?

1 ★ Yes 2 □ No 1(X) Yes 2 ☐ No ours efter death.

neral Director: After this certificatilled in y the funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 $\cancel{\square}$ Other (Specify) at Scene Certification: To XXYes 2 □ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical (t__ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23a. Cartifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. October 6, 2005 min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LING 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2005

	_ FOI	epartment of Health and Mental	2005 20100
	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N4 UU5 33 U8 of Death 3. Time of Death
Physician	Grace Leona Reed	Month	
/Medical Examiner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LXanine	Bartaure wastbucton Cow	for Glen Prience	Aus Krusel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Months Davs Hours Min. (Mont	h, Day, Year) Country)
Director	218-36-9472 1 M 2008 87 Yr Usual Residence of Decedent	s. 7–13	3-1918 MD
land ow	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
Many Tark	MD Anne Arundel Miller	csville	1 ☐ Yes 🂥 📉 No
or 284	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
of the Maryland of the Maryland reliems 23a or 28a-1 show the front be collised at Enneral Director	8394 Elm Road	21108	U.S.A.
er dez	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc. 	or No- 14. Race - American Indian, 5.) Black, White, etc.
72 hours efter natural, or Ite		1 ☐ Yes 2 🖾 No Specify:	Specify: White
2 hou 2 hou 2 hou 2 hou 2 hou 2		ecedent's Usual Occupation	16b. Kind of Business/Industry
A I A I D-U ed within 72 ho ygiane. ner than "natur. it, the Medical	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working ife. DO NOT use retired)	
filed will Hygien other the	10 Ho	omemaker	Own Home
	17. Father's Name (First, Middle, Last) Elmer Dillinger	18. Mother's Name (First, M Ella Miltz	iddle, Maiden Sumame)
		Mailing Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
re, Mar s 1 and 2 sh f Health and flem 27 is m other treum		7 Sorel Ct.; Millersvill	
S 1 ar f Hea item (20a. Method of Disposition 20b. Place of E	Disposition (Name of crematory or other place)	20c. Location - City or Town, State
Pages nent of nt: If i	1423Burial 2 Cremation 3 Hemoval from State	ven Memorial PK 10-15-200	05 Glen Burnie, MD
Saltimo permit Page Department of Important: if any in ury or	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Singleto	on Funeral Home, P.A.
Dep and per an	Hould Vanuer Mo1357	· · · · · · · · · · · · · · · · · · ·	
.8/	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or respirat	ory arrest, Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	Scular Accessor	30445
/Medical Examiner	Due to (or as a consequence of		
	Sequentially list conditions, if any, leading to immediate	ming queme	your
executed on and ial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	rife Duna	uan.
be executed sicien and burial-transit			
ate be ex hysicien a the burial	d. Meryetra	nlure	yan
Certificate oding physise as the	IF FEMALE:		
	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
. D 00 -	1 ☐ Yes 2-☐ No 9 ☐ Unknown	5 Other (specify)	
0 0		he underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
OrdS, requires t		- Infleter;	1 Yes 2 No 3 Probably 10nknown
0 > 00	Anseolentron		Was an 24b. Were autopsy findings available
The lav	-11	10)	autopsy prior to completion of cause of performed? death? Yes 2 No 1 □ Yes 2 No
yelcien: The is certificate director, pag	25. Was case referred to medical	26. Place of Death (Check of	only one)
F g is is	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outp		Residence 6 Other (Specify)
ding F	27. Manner of Ceath 28a. Date of Injury (Month, Day Year) Inj	ne of 28c. Injury at 28d. Description of Work? M 1 Yes 2 No	ribe how injury occurred
DIVISION of our Attending F after death. Director: After I in by the funera	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		tion (Street and Number or Rural Route Number,
Jor Att	4 Homicide determined building, etc. (Specify)		or Town, State)
spite hours merei y fillec		death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.		or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
To t To t	29b. Signature and little of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Caron Warmen a	0 2-46 Kel	Och 10 10 2005
15	30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) VARCUS CR., CA	resolved deser
State	51. Date filed (Month, Day, Year) 3 Registrar's Signature	wither and contin	VIEW CENTS ACOGI
Registra	11 1 2 2005	porte	

State of Maryland / Department of Health and Mental Hygien ? 15 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Michael DMEY 3:15 PM DAMES OctobER /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner 4c. County of Death HIGHWAM Ritchie BALTIMORE ARUNDEl If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 AM 2□ F Days Hours 216 20 1430 77 Yrs Director Maryland 6, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event, the Neclical Examinar must be notified at 10d. Inside City Limits Maryland Director Anne Arundel Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S. 4202 Ritchie Highway 21225 12. Was Decedent Ever in U.S. Armed Forces?

1 Armed Forces?
1 Ares 2 No If Yes, Give WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give WW II 1 ☐ Yes 2 1 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer CSX Railroad 10th parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any jury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Stephen Romey Anna Fabula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Ritchie Highway Lawrence Fay Romey / wife Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) 10/12/2005 Baltimore, Maryland Holy Cross Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Somerouse ama 23a Jan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HRTERIOSCUPROTIC CALDIOVASCULAR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be exacuted physician and s the burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACCIDENT CEREBRO VASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 X esidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: / 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide in 24 hours. the Funerel Dire 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 21776 My OCTOBER 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHANDUGR CT. 3001 MUNURA MA 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No.2005 For State Registrar Amend Item #29c&30 Per DVR G948 if 169/123/109 each 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:50 PM **Physician** 2005 0 Theodora C. Roston /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔯 F Nov 3, 1923 New York Director 075-18-6453 81 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or Itams 23a or 28a-f show the Medical Examiner must be extilled at 1 ☐ Yes 2√2 No Directo Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 USA 6105 Montrose Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) receptionist financial 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Skiadas John Michael Mavrogian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3661 Byron Circle Frederick, MD Helen Fitzpatrick/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Vicensee 3 Wade 21. Signature of Funeral Service L Ronald 8 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Respiratory DISTRESS 5 days **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) physician and the purial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Alzheimer's Demention 1 Yes 2 No 3 Probably 4 Unknown Completed Aspiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' Dysphafia Pour putational intake certificate 1 ☐ Yes 2 XN0 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₹No 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral i ⊯ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier Stulpa H. amin, MD ₽6002713 D052713 10/5/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shilpa H. Amin Hebrew Home of Greater Washington Rockville, Md. 20852 State

DHMH 17 Rev 1/2001

Registrar

OCT 1 3 2005

		State of Maryland / Department of Health and	Mental Hy	giene	0005	
		1 - State Registrer Certificate of Death	1000000	Reg. No.	2005	33111
Physici	an	1. Decedent's Name (First, Middle, Last) Louis Samuel Schmidt	2. Date of De Month	Day	2005	3. Time of Death
/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal			County of Death	
ж. ,		Baitimore Washington Medical Center Glen Burnie		X	Inne A	nurdel
Funeral Director	10	5. Social Security Number 6. Sex 17-38-0723 18 M 2 F 64 Yrs. Age (In yrs. last birthday) 11 Under 1 Year 11 Under 24 Hrs Months Days Hours Min		rth ay, Year) /19 4	9. Birth	place (State or Foreign intry) MD
		Usual Residence of Decedent	12/2/			
ahow	2	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🗽No
the M 28a-f	Director	MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code		10g. Citi	izen of What Cou	
h with	D	186 Dunlap Road 21122			6.A.	ŕ
r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5 Armed Forces? 11 Yes, specify Cuban, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-	14. Race - Amer Black, White	
72 hours after death with the Maryland 72 hours after death with the Maryland inetural; or Iteme 23s or 28s-1 show diest Examinat must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 Maried 1 Yes 2 Married 1 Yes			Specify: Wh	
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	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	, in the second	a 1		
filed within Hygiene. Ither then "		9 Class A Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle		emical Sumame)	
2 should be filed within and Mental Hygiens. Is marked other than aumatic avent, the Mental aumatic avent, the Mental aumatic avent, the Mental aumatic avent aumatic	To Be	Louis Carroll Schmidt Rosa S	aia			
ges 1 and 2 should to f Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R		er, City o	r Town, State, Z	ip Code)
1 and 2 Health Hem 27 other tra		Dorothy Schmidt / Wife 186 Dunlap Road,	Pasade:			
Pages 1 nent of H int: If its		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)			ocation - City or I	
그 문원들		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Bayview Crematory 10/ 22. Name and Address of Facility G	10/05	Bal	<u>timore</u> Tuneral	, MD Home, PA
Permi Impo		169 Riviera Dri				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death) a. METATIC LINE CANCE	2			Onset and Death
/Medical Examiner	Ţ	Immediate Cause (Final disease or condition resulting in death) a. METATIC LUNG CATICE Due to (or as a consequence of): METABOLIC BY CRITALOT	Porus			
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, Hill			
acuted ind transit	Examiner	that initiated events C.				
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eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deliv	,
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that the dead by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ନ୍ଧ ନ୍ଧ	d by		10	Yes 2	□No 3□Pro	bably 4 Minknown
aw requir	Completed		24a. Was		24b. Were aut	opsy findings available
sician: The law scerificate has t irector, page 2 s	Eog		auto perf	ormed? 2 No	death?	252 No
vita ician: sertific ector,	Be	examiner? Hospital:	ath (Check only			
Phys r this	To To	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Res			(fy)
nding P ath. r: After e funera	atlor	1 Solution 1 Signatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Attenthis certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	Street an wn, State	d Number or Rui	ral Route Number,
pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	a and due to the			
a Hos 24 hc a Fun letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	urred at the time.	date and	d place, and due	to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number			te signed (Month	
/		15 We bego MD 545149		Var	OBEZ	4 2005
5		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Burr	lie_	2106	9 2005
St	ate 4	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	OCT 1 3 2005 Refue It boule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 100 P.M 2005 June K. Schmidtchen 10 tober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept 23, 19 HOSPITAL

Age (In yrs. last birthday) n/a 5. Social Security Number 6. Sex Funeral Birthplace (State or Foreign Country) Months Days 1 □ M 2√2 F 84 Yrs. 217-12-0788 Director 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Iteme 23a or 28a-1 show eny injury or other treumatic event, the Maryletal Examiner results and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4408 Adelle Terrace 21229 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hutchison Kroeger Nora Giller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul A. Schmidtchen - son 4408 Adelle Terrace, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 KOther (Specify) Entombment Loudon Park Mausoleum 10/11/2005 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, dr shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arteroselevote Vascular) save Unknown Coronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery SchmidtehEN, June 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 20 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 200 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 2 Accident investigation 1 Tyes 2 No within 24 hours after death To the Funerel Director: completely fitted in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055849 30. Name and address of person eted cause of death (Item 23a) (Type, Print) Agnes Homita
32. Registrar's Signature 900 Caton Avene Bitimore Mary 31. Date filed (Month, Day, Year) State Goods Registrar

			State of Maryland / Department of Health and Mental	9
			1- State Registrar Certificate of Death	Reg. N2 005 33113
	Physic /Medi Examii	cal	Martha Helena Schmenner Mar	of Death
	Funeral Director		5. Social Security Number 228-07-6377 6. Sex 1 D M 2 F 93 Yrs. 1 D M 2 F P 1 D M 2 M P 1 D M 2 M P 1 D M	of Birth oth, Day, Year) 9. Birthplace (State or Foreign Country) 15, 1912 Virginia
	r 28a-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore 10c. Street and Number 10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2X1No 10g. Citizen of What Country?
5-0036	after death with	by Funeral	2 E Fallen Tree Court 11. Marital Status 1	United States
21215-0	C * W	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) homemaker	16b. Kind of Business/Industry
Maryland	ges 1 and 2 should be filed withi thof Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M	To Be C	Gordon Early Gilly 18. Mother's Name (First, Middle, Last) Gordon Early Gilly Martha Lena W	Villiams
	es 1 and 2 st of Health and f item 27 Is n r other traun	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No. 19b. Mailing Address (Street and Number or Rural	
Baltimore,	permit. Pages 1 Department of H Important: If itel any injury or ott		21. Signature of Funeral Service ticensee 22. Name and Address of Facility Hubbard	05 Big Stone Gap, VA
8760, <	cate be executed /Medical bhysician and Examiner is the burial-transit	dlcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
P.O. Box 6	The law requires that the death certificate ite has been signed by the attending physage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
Records, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
al Rec		e Completed	25 Mag ages retarred to madical	
Division of Vital	ding Phy I. After this funeral d	To B	examiner? 1 Yes 2 No	only one) Residence 6 □Other (Specify) tribe how injury occurred
Divis	To the Hospital or Attsm within 24 hours after death To the Funeral Director: completely filled in by the	l Certification:		ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
)	withi To th comp		D55391	29d. Date signed (Month, Day, Year) October 12, 200 J
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming Vi 3320 Denson Avenue, Bultimore, N 31. Date filed (Nonth, Day, Year) 9 32. Registrary, Signature	Maryland 21227
	Sta Registr	_		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 9:25 am OCTOBER MILDRED D. SIMPSON 10 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE
if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 1 X F 73 SEPT 29 1932 NORTH CAROLINA Director 215-28-5173 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County rai', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No MARYLAND BALTIMORE N/A Direct 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 2201 PRESBURY STREET 21216-3710 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2X Warried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: δ BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4yrs + TEACHER EDUCATION 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If Item 27 is marked othe any linky or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be DIXIE McNEIL 2 LUTHER MCNEIL SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2201 Presbury ST., Baltimore, Maryland, MD 21216 Mack B Simpson Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-05 GARRISON FOREST OWINGS MILLS, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE alken eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Inset and Death art1. Enter the disease, or com-shock, or heart failure. List only mmediate Cause (Final CARDIOVASCULAR DISEASE EARLS THEROSCLEROTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an has page 2 autopsy performed certificate 21 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After Natural 2 Accident 5 Pending 1 🗀 Yes 2 🗆 No death. investigation filled in by the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000554 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE NORTH CEASAR 821 the STREET 31. Date filed (Month, Day, Year) State OCT 1 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** Gladys I. Smith 5:00 A. M October 0 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 20, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🖺 F 97 Ĩ908 Mary land 212 28 9788 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b County 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Maryland Director Anne Arundel Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 21225 613 Hammonds Lane 238 Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hyglene.
sint: If item 27 Is marked other than "natural", or Items 23, and 10 to other fraturalic event, it. Medical Example II must Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: lf Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) C1erk Legg Mason Co. 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Samuel Koller Cora Belle Marshall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Shirley Quaskey / Daughter 3719 - 3rd Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland permit, Page Department of Important: If any njury or once. 10/13/2005 Bayview Crematory * 4 □ Donation 5 □ Other (Specify) Gonce Funeral Service, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 romerousk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List goty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Pnysician /Medical **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, sician Physician/Medical the β as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy atten for u Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ed by the a 1 Yes 2 No P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ HO 24a. Was an has le 2 autopsy performed? certificate 1 ☐ Yes 2 No Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral of Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 2 No 1 Tes investigation hours after death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier i 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 East egistrar's Signature 31. Date filed (Month State 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Yeer **Physician** Demeniuk 1539 redericik JC40ber 7 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner med. 0 len BUNNIE WASh-If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 ØM 2 □ F 72 Yrs 215 30 6268 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryle Department of Heelth end Mential Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28e-f show eny Injury or other treumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 460 Glendale Avenue U.S. 21061 Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0020 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sub-Station Balto. Gas & Eletric 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Jakym Semeniuk Mary S. Stankewicz ٩ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Semeniuk / son 460 Glendale Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/05 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Gonce Funeral Service, P.A. 22. Name and Address of Fecility 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Intervel Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, or heart failure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner signed by the ettending physician end d be deteched for use es the burlel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): pege 2 should be deteched for use es the 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 1 ☐ Yes 2 ☐ No Attending Physicien: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Ves 2 No ဥ 1 Inpatient 2 KR/Outpatient 3D DOA After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours efter death.
To the Funerel Director: Aft completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number eouty 0006054

State Registrar

31. Date filed (Month, Day, Year) OCT 3 2005

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695 America Cf 21035 Registrer's Signature

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		1	For State Registrar	Sta	ate o	of Marylan				ealth a Death	and M		giene		5	331	17
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	filed within 72 hours after death with the Maryland Hygiene. the than Insturat, or iteme 23e or 28e-f ehow ent, the Madical Examination unities notified at	Funeral Director	11. Maritat Status	12. W	/as Dec	cedent Ever in U	I.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race -	American White, et		
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat, or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	Be C	17. Father's Name (First, Middle,									(First, Middle					
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PEGGY SOLDMON.

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			State Registrar 1. Decedent's Name (First, Middle, L	act)	_	Ce	rtificate	e of L	Death		2. Date of De	Reg. No.20		33 {	3
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			Usual Residence of Decedent		10a Cin	, Town or Lo	pation						1	0d. Inside City Limits	_
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State of Maryland / Department of Health and Mental Hygien 0 15 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 2005 Veronica F. Tait October 0 8:50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Months Hours 1 ☐ M 2 💢 F MAR 4, Pennsylvania Director 188-26-0950 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or itema 23a or 28a-f ahow Ite Medical Exercises must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21228 3 North Symington Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: if itam 27 is marked other than "natural", or ite may injury or other traumatic avent, the Mudical Exercisms and. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify White þ 3 XWidowed 4 ☐ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Efementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Komishock Frank Petak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 North Symington Avenue Catonsville, MD 21228 Franklin Tait/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/14/05 Baltimore, MD 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 Edward & Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAncer **Physician** 2 Ma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Lung disease COVO notry bstrotwe Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No or Attending Physician: after death. After this certification 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Be Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how intury occurred 27. Manner of Death Certification: 5 Pending 1 Naturat 1 ☐ Yes 2 ☐ No investigation Diractor: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel cities 24 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 ano completed cause of death (Item 23a) (Type, Print) 30. Name and address of person harles St. Balts. Md 2,20x 6701 6me 31. Date filed (Month. Tay Year) Registrar's Signature State 2005 Registrar

		Formerd Item #19a Per state Registrar Amend Item 1. Decedent's Name (First, Middle, Last					2. Date of Dea	ath Day Yea	3. Time of Dea			
Physici /Medio		Allyn True					OCTOL.	106 200	S 1.91			
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Funeral		5. Social Security Number 6. Se	7 M 2 T E	yrs. last birthday	Months Days		8. Date of Birti (Month, Day	y, Year) (irthplace (State or Fo			
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natural', or Items 23a or 28a-1 show Iteal Examinar must be notified at	ţ	MD Harford		Havre	de Grace				1 □ Yes 2			
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S Harris	by Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.			
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lith ar 27 is r trau		Betty Morris Betty Morrin/frie	nd	3613	Hays Roa	ad Aberdee	n, MD	21001				
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s cer direct	To B	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3□ DOA Ot	thon!		lence 6 Other (Sp	pecify)			
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within 24 hours after death To the Funeral Director: completely filled in by the	edical	29b. Signature and title therifier	rullo Mo	(Item 23a) (Type	14	2800	1/1/10	10/7/	25			

True Allyn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1454 PM WOULDRIDGE OUTOBER JOHN 10 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RANDALLSTOWN HOSPITAL BALTIMORE NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months 200-20-3293 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County rel', or items 23a or 28e-f show Examiner must be notified at 1 Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA o filed within 72 hours after death val Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Yes, Gir Black, White, etc. 2 Married 1 Never Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Mudicul 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) 18. Mether's Name (First, Middle, Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o Cobinsor Rural Route Number, 20b. Place of Disposition (Name cemetery, crematory or oth Date ethod of Disposition Department of H Importent: If ite eny injury or ot Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sixture of Juneral Service stown, MD 21133 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** atom resnir Sequentially list conditions, Due to (or as a cons unnce of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ò Day 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 1 Yes 2 00 Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 inpatient 2 ER/Outpatient 3 DOA P After this funeral c Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Natural 2 Accident after death. 1 🗌 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D0059736 10 2005 actoher ra fon

State Registrar

DHMH 17 Rev 1/2001

OCT 1 3 2005

31. Date filed (Month, Day, Year)

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

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HOSPITAL

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			1 - For State Registrar	State of Mary		artment of H		-		
	Physici		Decedent's Name (First, Middle, Last Deborah K				-	2. Date of Deat	Day Year	3 ing of poem 2
	/Medio Examin		4a. Facility Name (If not institution, given Baltimore Washing	e street and number)	Center	4b. City, Town, or		10-10	4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 259–15–3826		yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 8,		place (State or Foreign intry) CUCKY
	Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 410 King George	Drive		10f. Zip Code 210	61	1	0g. Citizen of What Cou USA	intry?
396	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Plygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Exeminer must be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: B1a	, etc.
21215-0036	within 72 housne.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired;	uring most of wor	king	16b. Kind of Business/Ir	,
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, Maryland	and 2 shows alth and N 27 is made or treuma		19a. Informant's Name/Relationship (, Jr. /Husba	and 410 K	ing Georg		Glen Bur	. City or Town, State, Zi nie, Maryla	
Baltimore,	Pages 1 ament of He tent: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	letro Cre	matory or other place matory In	c. 10/1	3/05	20c. Location - City or T Baltimore,	
Bal	permit Deper Impor any in		21. Signature of Funeral Service (Cor Thornas Gregor	y-		2. Name and Address remation 99 Freder	ick koad		re, Marylar	nd 21228
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.O. Box 687	The law requires that the deeth certificate to has been signed by the ettending phy age 2 should be detached for use as the	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
۵.	w requires that is been signed by should be deta	ed by Ph	Part II. Other significant conditions of	contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	s 2 No 3 Pro	
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	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medicel Exen	nysicien: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the time vestigation, in my op	inion, death occur	red at the time, da	ite and place, and due t	o the cause(s)
	6 1 € 1 €	-	29b. Signature and title of certifier	M A .	^	500	43977	D -	d. Date signed (Month,	700C
1	up .		30. Name and/address of person who	completed cause of death	(Item 23a) (Type,	Print) NR, Alex	Burr	M. M	mo. 5/10	061.
	Sta Registr		31. Date filed (House Day, Year)	5 Plane	Signature	w		** (500-11)		

DEBRA WAIGHT

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yeer 30 A M October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bultwove fear If Under 24 Hrs. 8. Maryland Medical Center NA University Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number D 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 10 M 2□ F Months Days Hours 5 Director 218-57-2320 4-13-2000 Md Usual Residence of Decedent 10a. State 10b. County s 23a or 28e-f show 10c. City. Town or Location 10d. Inside City Limits 1♥ Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Pennsylvania Ave.Apt. B-11 21217 USA or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Mudical Exposurer: Black White etc. hours after Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Maryland 21215-0036 þ 1 ☐ Yes 2 😾 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Black "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Child Child 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rodney Wheaden, Jr. Linda Blackburn Wheaden, UT-1 LITING.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21217 19a. Informant's Name/Relationship (Type, Print) Linda Blackburn 1502 Pennsylvania Ave. Apt. Mother B-11, Baltimore, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) injury or permit. Page Department o Importent: If any injury or Randallstown, Md. Mem. Park 10-14-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility pnce Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Bo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Shoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due II (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physicien Physiclan/Medical the IF FFMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page Retardation certificate Division of Vital 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melissattawkins-Holt South Greene Street Balto, MD 21201 32. Registrar's Signatur 31. Date filed (Month, Day, Year) OCT 1 3 2005 Registrar

		For State Registrar	State o	f Maryland		artment of H		nd Menta	al Hygien	2005	33124
Physic	cian	Decedent's Name (First, Middle		- 1 1		C			ite of Death onth Da		3. Time of Death
/Med		William 4a. Facility Name (If not institution	Kenda			Wood, Sr. 4b. City, Town, or		Death	10	County of Dea	th Ton
Exam	iner	103 E. John Av	_	11001)		Linthicu				Anne A	
Funera	1	5. Social Security Number		7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24	Hrs. 8. Da	te of Birth onth, Day, Year		thplace (State or Foreign
Directo		219-01-7447	OXOXM 2□F	84	Yrs.	Months Days	Hours	Min. (Me	onth, Day, Year -13–1921	MD	ountry)
P.		Usual Residence of Decedent		40.00							
arylar	_	10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
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with th	Funeral Director	10e. Street and Number				10f. Zip Code				itizen of What Co	ountry?
s 23g	rai	103 E. John Ave	12 Was Dags	edent Ever in U.S.	12.1	21090	ienanie Origin	2 (Specify V		J.S.A. 14. Race - Ame	arican Indian
ter de Item	Į.	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Fo	rces?	13.	Was Decedent of H f Yes, specify Cuba	in, Mexican, F	Puerto Rican,	etc.)	Black, Whit	
urs af	by	3 [™] Widowed 4 Divorced	If Yes, Giv Year or D	re		1 ☐ Yes 2€ No	Specify:			Specify: W	hite
ified within 72 hours after death with the Maryland Hygiene. Hygiene "neturel", or Items 23e or 28a-f show ent, it e Mouteal Examine rough or individual.	ted	15. Deceden		1	16a. Deced	dent's Usual Occup	ation	f working	16b. F	Kind of Business	/Industry
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allyidillo 2 12 should be filed within nd Mental Hygiene. marked other than umatic event, tre M	ုင	Eugene H. Wood		-				h Durh			
©		19a. Informant's Name/Relations				ng Address (Street					Zip Code)
T, E		William K. Wood 20a. Method of Disposition	, Jr. / S			E. John A		JINTNIC Date		.ocation - City or	Town State
Pages nent of I		1 Burial 2XX Cremation	_	State !		sition (Name of matory or other place	1	12 20		,	
mit. Pages partment of portent: If it y injury or or	ىن.	* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Cnesa		e Cremati 2. Name and Addres				vensvil	
partitione, interpretation of the alth a popular in the any injury or other trees.	Suce	1701/1	Varian	/Mais		Second A					
R = 1		23a. Part1. En Line disease, or	complications that c	aused the death. I							Approximate Interval Between
Physiciar		shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	ŧ:	a visa a	1-				Onset and Death
/Medica		disease or condition resulting in death)	a. Due to	or as a consequen	nce of):	-077 23					
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cate be executed physician and the burial-transit	<u> </u>	recoming in activity state	Due to t	(or as a conseq u en	iee oi).						
The ECOTOS, P.O. BOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d								
wrequires that the death certific been signed by the attending planel be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy						23d. Date of de	livery
BOX leath cerr attendin	ciar	in the past 12 months?		irth 2 Fetal de ant at time of deat		Ectopic pregnancy Other (specify)				Month	Day Year
the d	hysl	9 Unknown	9□ Unkno	own							
s that	by P	Part II. Other significant condition	ons contributing to de	eath but not resultir	ng in the u	nderlying cause give	en in Part I.	23	Be. Did tobacco	use contribute to	the cause of death?
w requires to been signer should be									1 ☐ Yes 2	.□No 302Pi	robably 4 Unknown
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The The ate he	mo							10	performed? ☐ Yes 2 No	death?	2□No
VICAL icien: T certificat ector, p	Be (25. Was case referred to medical examiner?						f Death (Chec	ck only one)		
Physic Physic rthis or ral dire	ပို	1 ☐ Yes 2 ☐ ₩6		npatient 2 ER			4 🗀 140131			6 ☐Other (Spe	city)
ling F	lon:	27. Manner of Death Natural 5 Pendin	9	of Injury th, Day Year)	Bb. Time of Injury	Wor	yat k? Yes 2 □ No	į	escribe how inju	iry occurred	
Attending at death. ector: After by the fune	icat	2 Accident investig	not be ass Blace	of Injury - At home	a farm str		165 2 110		cation (Street a	nd Number or Ri	ural Route Number,
after Direction by	ertification:	4 Homicide determ	buildi	ng, etc. (Specify)	J, (Q(1)), (3)	oot, lactory, office			ty or Town, Stat		,
spite nours nerel	a C		g Physicien: To the								
To the Hospitel or Attending Physicien: The tav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical one)		ner stated.							
To the To the Comp	Σ	29b. Signature and title of certifie		1	7	29c. Licens	e number	. 0	29d. Da	ate signed (Mont	h, Day, Year)
		1/			/		1/87	LO A	(0-12	05
1		30. Name and address of person	who completed caus	se of death (Item 23	За) (Туре,	Print)		<i></i>	0		h, Day, Year) - 05 - 21061
10		31. Date filed (Month, Day, Year)	MB 16	legistrar's Signature	o de	Hwy S	wite 10	16, 61	ien Dur	NE, M	7 31061
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	3
State of Maryland / Department of Health and Menta	ll Hygiene 2 () () 5 3 3
Certificate of Death	

	1 - State Registrar
	1. Decedent's Na
Physicia /Medic	Joseph
Examin	4a. Facility Name
	Johns H
Funeral Director	5. Social Security
7	Usual Residence

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other treumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1 - State Registrar				Cer	tificat	te of D	eath			Reg. No.			
an	Decedent's Name (F									2. Date of De Month	Day	22 , 200	3. Time	
cal	Joseph Wi									Septem				P
ner	4a. Facility Name (If no Johns Hopk			nber)			. Town, or l ltimo:		r Death		4C. C	County of Dea	itn	
	5. Social Security Numl			7. Age (In yrs. la	st birthday)			If Under 2	24 Hrs. 8	B. Date of Birt	th		rthplace (State	or Forei
	3. Goolar Goodiny Ivania		M 2□F	68	Yrs.	Months	Days	Hours	Min.	(Month, Da an 22,	y, Year)	G	ountry)	unk
	Usual Residence of De	cedent								an 22,	175.		-	
	10a. State 10	b. County		10c. City	, Town or Loc	cation							10d. Inside	-
cto	MD				Balti	more								s 2 🗆 N
Oire	10e. Street and Numbe		W -			10f. Zi	p Code	0.1.0.1.6			10g. Citize	en of What C	ountry?	
Funeral Director	1719 N. B							21213				USA		
nue	11. Marital Status	unk	Armed Fo		a li	Vas Dece Yes, spe	dent of His ecify Cuban	, Mexican	nn? (Spec , Puerto Ri	fy Yes or No can, etc.)	1	 Race - Ame Black, Whi 		
by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes If Yes, Giv Year or Da	е	unk 1	☐ Yes	2 X No	Specify:			5	Specify:whi	Lte	
pa r		. Decedent's Ed		103.	16a. Deced	ent's Usu	ial Occupat	ion		unk	16b. Kine	d of Business	:/Industry	un
Siet	(Specify o	only highest gra	de completed)	1.15	(Give I	kind of wo	ork done du ise retired)		of working				,	
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ToB														
	19a. Informant's Name	/Relationship (7	Type, Print)		19b. Mailin	g Addres	s (Street ar	nd Numbe	r or Rural	Route Numbe	er, City or	Town, State,	Zip Code)	
	O.C.M.E.				111	Penn	Stre	et Ba	altim	ore, M	D 21	.201		
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State													
Ιi	4 □Donation 5 ②Other (Specify) in state													
l	21 Signature of Funeral Service Consee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201													
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Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):													
dical		•	d											
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by Ph	Part II. Other significa	nt conditions o	ontributing to de	eath but not resu	lting in the un	derlying	cause giver	n in Part I.		23e. Did to	obacco us		o the cause of	
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Completed	DIABETI	ES MELLI	TUS							24a. Was	osv	24b. Were a	utopsy findings completion of	s availab
E										1 Yes	rmed? 2 □ No	death?		
	25. Was case referred examiner?	to medical							of Death (Check only o	one)			
B	1 X Yes 2 No		Hospital: 1 🗆 I	npatient 2	R/Outpatien			4 🗆 1401				□Other (Spe	ecify)	
To Be			28a Date	of Injury th, Day Year)	28b. Time of Injury		28c. Injury . Work?	?		d. Describe I	now injury	occurred		
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Certification: To B	27. Manner of Death XXXNatural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation Could not be determined	9 28e. Place buildii	ng, etc. (Specify)			. Harris		City or To	vn, State)			m <i>ber</i> ,
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Amend item#19a, per FH, G848 10/13/05 TT State of Maryland / Department of Health and Mental Hygiene 0 0 5 33126 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Vear Carrie Mae Wallace 9:30 AM 8 OCDSEN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Health Care Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 9/10/1916 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 406-07-1067 1 M 2 X F 89 Yrs Director Indiana Usual Residence of Decedent with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits worke r Itema 23a or 28a-f ehov ir er must be notified at MD 1 ☐ Yes 2 ☑ No Completed by Funeral Director Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4907 Telegraph Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "nature" once. 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3℃Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12Secretary Building Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willaim Amacher Margaret Wertz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name Relationship (Type, Print) Marilyn Warole/Daughter 4907 Telegraph Road Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State National Crematory 10/13/05 * 4 ☐ Donation 5 ☐ Other (Specify) Falls Church VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - ALZHOMEN TYPE DEMENTA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. P been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CEREROVOSCULAL ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No FIBRILLATOR 24a. Was an autopsy page performed? certificate **3**€ No 1 🗌 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other Amount Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred **○**Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Lexifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pletely (Check only one) 29b. Signatura and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 453419 Octomer 11, 2005 ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. 1331 TELEGRAPH ROAD, RISING SUN, MD DOWHAM. KODNEY 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** John B. Widdup 9:10 p. October 9, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Heron Point Retirement Community Queen Annes If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mooths Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Şex 1 X M 2 □ F **Funeral** Months Director 86 484-10-3908 July 18, 1919 lowa Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County or 28a-f show the Medical Examiner must be rotified at 1 ☐ Yes 2 No Director Maryland Queen Annes Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21620 Items 23a U.S.A. 334 Heron Point death by Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 NYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 2 Married 1 Never Married ō If Yes, Give Year or Dates: WWII 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Insurance Elementary/Secondary (0-12) College (1-4or 5+) Insurance Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fill iment of Health and Mental H tant: If itsm 27 is marked ott ပ William Widdup Florentine Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 Herron Point Chestertown, Maryland 21620 Ms. Louise Widdup Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. • 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2005 Ellicott City, MD St. John's Cemetery gn Jury of Funeral Service Licens 22. Name and Address of Facility Slack Funeral Home, P.A.

Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final lease or condition sulting in death) CONGUSTL **Physician** CTEMART /Medical **Examiner** MORTIC STUNIOSU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 should be 2 No 3 ☐ Probably 4 ☐Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy page performed 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Jursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and mann To the 29d. Date signed (Month, Day, Year) and title of certifie 29b. Signature 00060301 Ause of death (Item 23a) (Type Print) RD 572-5 CHOSTENTAUN, MD completed MICHAEL E) MERC . Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

81	7		1 - For Unpend Item 2	State of Mar 23a,27,28a-	yland f pe	/Depa r me	utmen 4848 titicat	185 H	ealth a Death	nd Me tas	ental Hy	giene	200	5 33	3128
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las Arnold W. Yanches) Arnold W. Tanches HARBOR HOSPITAL	ki			4b. City,	Town, or	Location of E CIT	Death Y	2. Date of De Month OCTOBE	R 6,	2005 County of De	3. Time 1441	of Death
	Funeral Director		5. Social Security Number 216-92-2747 Usual Residence of Decedent	7. Age ('In yrs. Ia	st birthday) Yrs.	If Under Months		If Under 2 Hours	4 Hrs. 8	B. Date of Bir (Month, Da 11/20/	th ly, Ye <i>ar)</i> 1964	9. 8 Ma	Sirthplace (State Country) ryland	e or Foreign
	the Maryland 28e-f ehow	rector	10a. State 10b. County Maryland N/A 10e. Street and Number	1		Town or Lo Balti		Code				10a. Citi	izen of What		City Limits
36	be filed within 72 hours after death with the Maryland ttal Hygiene. od other then "natural", or lems 23s or 28e-f ehow event, the Medical Examiner must be notified at	by Funeral Director	28 S. Madeira Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S		21 Was Dece	231 dent of Hi city Cuba	ispanic Origi n, Mexican, Specify:	in? (Spec Puerto Ri	fy Yes or No	Unit	ed Sta	tes merican Indian, hite, etc.	
Maryland 21215-0036	filed within 72 hou Hygiene. Ather then "nature ent, the Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	lucation		16a. Deced (Give life. I Wareh	kind of wo DO NOT u	rk done d se retired	furing most ((First, Middle	Pai		ss/Industry	
Marylano	2 should and Mer is marke	To Be	Arnold J. Yanches	Type, Print)				(Street a	Caroly	yn Ch	nriste Route Numbe	nsen er, City o	r Town, State		
Baltimore, I	m O		Carolyn Yancheski 20a. Method of Disposition Burial 2 Cremation 3 Carolina 4 Donation 5 Other (Specify	Removal from State	20b. Pla cei	ace of Dispo metery, crer Stan	sition (Nar natory or d islau	ne of other plac LS	e) 10	Da 0/13/	te /2005	20c. Lo	imore,	d 21231 or Town, State Maryla	
Ball	permit. Page Department of Important: if any Injury or		21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or being	Miles)	4	01 S.	Che	ster :	Stree	et Balt	timo		ral Hom ryland	
8760,	death certificate be executed Wedicare We entending physicien and dor use as the burial-transit	ical Examiner	shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conductor of the conductor) Due to (or as a conductor) Due to (or as a conductor)	into: conseque	ence of):	ion							Interval E Onset an	
O. Box 6	that the death certifica led by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 l 4 Pregnant at tin 9 Unknown	Fetal	death 3	Ectopic pr						23d. Date of d Month	delivery Day	Year
Records, P.	The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions c	ontributing to death but i	not resul	ting in the u	nderlying c	ause give	en in Part I.		1	obacco u Yes 2		to the cause o	f death? Unknown
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Division of Vital	Phys this at dir	cation; To B	examiner? 1 Nes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation	10-0-01	13	R/Outpatier 28b. Time of Injury		28c. Injury Work	ar: 4□ Nurs	sing Home		dence	6 □Other (Sp y occurred	unk	
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	the Hospital hin 24 hours of the Funeral upletely filled	Medicai	one) 2 XMedical Exam	ysician: To the best of a niner: On the basis of ea and manner state	xaminatio	viedge, deati on and/or in	vestigation	, in my of	oinion, death	place, an	d due to the	date and	I place, and d	ue to the cause	
	To with		29b. Signature and title of certifier Ambly July 30. Name and address of person who	hull, MS completed cause of dea	th (Item	23a) (Type.		c. License	CME				-	7, 2005	
	Sta	ate	Pamela E. 5003 31. Date filed (Month, Day, Year)	Hall, MA	s Signatu	111 P	ENN S		T, BAI	LTIMO	ORE, MA	ARYL	AND, 21	L201	
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UNKNOWN 05-60	OO4	t 1 State Under		* -				Health and I The OS Death			9	33129
		Registrar 1. Decedent's Name (Ce.	rimcate o	Death Car	2. Date of De			3. Time of Death
Physici /Medio		Jose	Er1e	Arita					SEPT.	2, Da	2005 Year	6:15 PM
Examin		4a. Facility Name (If n	•		ber)			, or Location of Death	1	1	County of Deat	
Funeral		5. Social Security Num			. Age (In yrs.	. last birthday)	HYATTSV		8. Date of Bir	rth	PRINCE (
Director		561-97-422	2	X) M 2□ F	60	Yrs.	Months Day	s Hours Min.	(Month, Da May 29,	ay, Year)	15 E1 CS	hplace (State or Foreign untry) Salvador
Maryland		Usual Residence of D 10a. State	10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
Ind 21215-0036 be filed within 72 hours after death with the Maryla ital Hygiens at the Maryla id they then "natural", or liems 53s or 28s-1 ehov event, the Madical Examiner must be notified at	Director		Los Ange	eles	Lo	s Ange	les					1 ☐ Yes 2X No
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36 after or Its	F	1 Never Married	_	Armed Ford 1 Tes 2 If Yes, Give	X No	1	lf Yes, specify Ci 1. X Yes 2 □ N		o Rican, etc.)		Black, White Specify:	e, etc.
hours tural;	ed by	3 ☐ Widowed 4	Divorced Decedent's Ed	Year or Dat	es:		dent's Usual Occ	El Salvad	orian	165 4		spanic
1215-0036 within 72 hours after death ene. then natural; or Items 23 the Medical Examinar must	Completed	(Specify	only highest gra	de completed) College (1-	4or 5+)	(Give	kind of work dor DO NOT use reti	ne during most of wor red)	king	100. K	THE OF BUSINESSY	industry
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and 2 d be filed antal Hygi ced other	o Be	17. Father's Name (Fi						18. Mother's Nan		, Maiden	n Sumame)	
ore, Maryland 212'ss 1 and 2 should be filed within of Health and Mental Hygiene. I (Imm 27 is marked other then returnatic event, the Mental Hygiene.	ို	19a. Informant's Nam				19b. Mailir	ng Address (Stre	Socorro et and Number or Ru	CO TO COMMO	er, City	or Town, State, 2	Zip Code)
and 2 ealth a m 27 is		Jose Erle		on				ew Ln. Dal	-	VA	22193	
Baltimore, Maryland 21215-0036 Semit. Pages 1 and 2 should be filed within 72 hours aft Oppartment of Health and Mental Hyglens, or moportant: if item 27 is marked other then "satural; or eny lolury or other treumatic event, the Modical Examples.			Cremation 3 🗍		tate 20b.	Place of Dispo cemetery, crer	sition (Name of matory or other p	1	Date		ocation - City or	
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			fallure. List only	plications that ca one cause on ea	used the dea ch line.	th. Do not ent	er the mode of d	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	nai	a. Drowni								Criset and Death
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pe si	iner	Sequentially list cond if any, leading to imm cause. Enter underly Cause (Disease or inj	itions, lediate		ras a consec	quence of):					2	
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P.O. het the de sid by the detached	hysic	1 ☐ Yes 2 ☐ ! 9 ☐ Unknown	No	9 Unknov		ueath 5	Other (specify)					
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redsath. ector: After this certificate has been signed by the attending physician end ector: After this certificate has been signed by the attending physician end by the funeral director, page 2 should be detached for use as the burial-transit	by P	Part II. Other significa	ant conditions co	ontributing to dea	th but not res	sulting in the u	nderlying cause (given in Part I.		_		the cause of death?
Division of Vital Records, for Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be control of the funeral director.	eted								1 🗆 '	Yes 2		obably 4 Dunknown
II Rec The law sete has b	Completed								24a. Was autoj		24b. Were au prior to death?	topsy findings available completion of cause of
Vital Fincien: The certificate	60	25. Was case referred	d to medical			_		26. Place of Dea	th (Check only o	2□No		2□ No
Of V Physic this ce al direc	To B	examiner? 1X Yes 2 □ No	0			ER/Outpatier	I 3 DOA	other: 4 ☐ Nursing H			6.XOther (Spec	city) AT SCENE
On C	ti On:	27. Manner of Death	5 Pending	Foundath	, Day Year)	Found	W	uryat lork? ∐Yes 2 1 2∏No	28d. Describe			
VISION Atten	Certification:	2. Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	7 Z-U_			eet, factory, offic		Subject 28f. Location (Street an	nd Number or Bu	ral Route Number,
Dir Hospitat or 24 hours afte Funeral Dir tely filled in I	Cert	4 _ Homicide		Found	l in a	creek			Terrace	Hya	⁹ 7006 Hi ttsville	ighview Md
Divisit To the Hospital or Attention within 24 hours after deall To the Funner Director:	Medical	29a. Certifier 1 (Check only 2)	Certifying Phy Medical Exam	ysician: To the baseliner. On the baseliner. and manner	sis of examina	owledge, death ation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	and due to the	cause(s)) and manner as	stated
To the within 2 void the complete	Mec	29b. Signature and tit	tle of certifier	and mailne	atalou.		29c. Lice	nse number		29d. Da	te signed (Monti	n, Day, Year)
		- Margi	MIE ()	he You	19		0.0	C.M.E		S	EPT. 3,	2005
		30. Name and addres		completed cause	of death (Ite	m 23a) (Type, 11 PFN	Print) N STREET	,BALTIMOR	E, MARYLA	AND	21201	
Sta	ite	31. Date filed (Month,	, Day, Year)	32. R	JE UL			, , , , , , , , , , , , , , , , , , , ,				
Registi				2005	Server	ature	code					

			1 - For State Registrar		State of M	arylan	id / Depa	artmer	nt of H te of L	ealth ar Death	nd Me	ntal Hyg	iene2	005	3313	30
	Physici /Medi	cal	Decedent's Name (First Rena 4a. Facility Name (If not ii)	Faye	Alle			4h Cihi	Tourn or	Location of [S	Date of Deat Month	27	2005	3. Time of Dea /406	M.
	Examir	ier	PININSULA A	egionn	Med 11	n Ci	UNIW		5,	921564	my			MICIM		
	Funeral Director		5. Social Security Numbe 214–36–5903 Usual Residence of Dece	1	X 7. A	66 (In yrs.	last birthday) Yrs.	Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, 1/25/19	^{Yea} r) 39	9. Birthp Coun Mary	lace (State or Foi try) land	'eign
	Maryland -f show	tor	10a. State 10b.	County Wicomi	co		y, Town or Lo							1	0d. Inside City Lis	
	ath with the Marylar 23a or 28a-f show	Funeral Director	10e. Street and Number Lot 38, B	ohnak '	Trailer P	ark		10f. Zi	Code 2182	26		11	0g. Citizen USA	of What Coun	try?	
036	hours after death with the Maryland tural', or Items 23e or 28e-f show al Exanties must be rutified at	by	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 🔼		12. Was Decedent Armed Forces' 1 Tyes 2 If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 Yes		spanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	E	Race - Americ Black, White, acify: Wh		-
9500-61212	within 72 ene. than "nat	Completed		Decedent's Ed ly highest grad (0·12)		5+)		dent's Usu kind of w DO NOT u	ork done d ise retired	ation furing most of	f working			f Business/Ind	dustry	
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	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/P									Route Number, Grove,			Code)	
Baltimore,	of H of H if Item		20a. Method of Disposition 1 □ Burial 2 □ X re 4 □ Donation 5 □ 0	mation 3 🗆			Place of Disponentery, cres	matory or	other plac		Date /28/0			on - City or To bury, I		
Balti	permit. Pag Depertment Important: any injury o		21. Signature of Funeral	Service Licen	ans	B	f 2	H8T18	od Addres now	fühera Hill R	l Ho	me Proi Salisbu	essic	onal As ID 2180	sociatio	on
,160,	Physician and /Medical Examiner (the private state)	dical Examiner	23a. Part. Enter the dis shock, or heart fail. Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the sequential of any, leading to immedicause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	(a. Due to (or as	a conseq	atiquence of):					· Srue			Interval Betweer Onset and Death	
O. Box 68	the death certifical y the attending phy ched for use as th	ysiclan/Me	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 Yes 2 No 9 Unknown	Hant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic p Other (s						Date of delive Month	ry Day Year	
Records, P	The law requires that the dei	Completed by Physician/Med	Part II. Other significant		ontributing to death i	out not res	ulting in the u	nderlying	cause give	on in Part I.	_	1 ☐ Ye	s 2 No	3 Proba	e cause of death ably 4 Munkno	own able
_	Physicien: The lav this certificate has al director, page 2	е Сош	25. Was case referred to	medical								autopsy perform 1 Yes 2	ned? ★ No	death?	npletion of cause 2 No	of
Division of VI	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	To B	examiner? 1 ☐ Yes 2 💢 No 27. Manner of Death	-	Hospital: 1 Nnpati 28a. Date of Inj (Month, Da	ury	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 Nursi	ng Home	5 Reside	nce 6 🗆)	
DIVIS	Itel or Atterics after deital Directo	Certification:	4 🗍 Homicide	Could not be determined	building, e	tc. (Specif	y)					City or Town	, State)		Route Number,	
	he Hosp n 24 hou he Funei pletely fiil	Medical	29a. Certifier 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Certifying Phy Medical Exam	ysician: To the best iner: On the basis of and manner s	n examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date and pointion, death	olace, and occurred	d due to the ca at the time, da	use(s) and ite and plac	manner as sta e, and due to	ated. the cause(s)	
	Tot Tot	Σ	29b. Signature and title o	of certifier		7	00		C. License		410		d. Date sig	ned (Month, I	Day, Year)	
	B		30. Name and address of Simona E		ompleted cause of OE. Carr		n 23a) (Type,	Print)	uru	Md.	218	201	1-			
7	Sta Regist		31. Date filed (Month, Da	y. Year) P 2 9 21	32. Regist		ature	· W	- //	<u></u>						

1980-28-0061

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year **Physician** Destiny Madison Avers 1,2005 1400 September /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sinai Hospital
5. Social Security Number UN 6. So Baltimore City
If Under 24 Hrs.
Hours Min.
Baltimore City
(Month, Day, If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs 2005 Director Usual Residence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Baltimore City Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? re Ave.

12. Wes Decedent Ever in U,S.
Armed Forces? Funeral 1652 E. Belvedere Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 2 3 Widowed 4 Divorced Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/AN/AN/A17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) <u>Christopher Erin Ayers</u> <u>Eustacia Monique Madison</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1652 E. Belvedere Ave. Balto., MD 21239 <u> Eustacia Madison / Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 22 ☐ Cremetion 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ☐ Other (Specify) ☐ Other ☐ BALTIMORE, MD HOSPITAL 11/05 22. Name and Address of Facility SINA ! HOSPITAL OF 2401 W. Believe Hug.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE 401 W. Believere Ave PALTIMORE, MD ZIZI Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Severe Prematurity Examiner Due to (or as a consequence of): Physician/Medical Examiner lew requiras that the death certificeta be executed ettending physician and I for use es the bunal-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the et Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No þ ours efter death.

eral Director: After this cartificate has been si filled in by tha funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🙀 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigetion 1 ☐ Yes 2 TNo N/A N/A6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide N/A 24 hours N/A152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier To the within 2 29c. License number 29b. Signature end title of certifie 29d. Date signed (Month, Day, Year) Q5 LUD P16530 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Tameeka Law, M.D. 01 W. Belvedere Ave Baltimore, MD 21215
32. Registraf Signature
2005 March & Appell Sinai Hospital 31. Dete filed (Month, Dey, State

DHMH 16 Rev 6/95

Registrar

			For State Registrar	State of Marylan		ent of Health and ate of Death	Mental Hygier	_ Z U U :	33132
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give		A 4b. Ci	nder Sor ty, Town, or Location of De) 08 (Day Year 5 05 4c. County of Death	3. Time of Death 2 53 M
	Funeral Director		5. Social Security Number W 6. Security Number W 10	Newtist TD: 7. Age (In yrs.)	Jast birthday) If Unc OYrs. Month	ler 1 Year If Under 24 H s Days Hours M			nplace (State or Foreign Unitry)
	the Maryland 28a-f show		10a. State 10b. County Prince (Teorges Lo	y, Town or Location RINAM 100	Zip Code	10a	Citizen of What Co	10d. Inside City Limits 11 Yes 2 No
92	be filed within 72 hours after death with the Maryland Hygiene. Hygiene do they than "natural", or Items 23s or 28s-f show svent, the Medical Examinar must be notified at svent, the Medical Examinar must be notified at	ᆵ	8 108 M L K / 11. Marital Status 1 Never Married 2 Married	## HOY APT ## 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 B No If Yes, Give	734 S. 13. Was Der If Yes, s	20706 cedent of Hispanic Origin? pecify Cuban, Mexican, Pu		14. Race - Amer Black, White	ican Indian,
21215-003	filed within 72 hours Hygiene. Ither than "naturs!", ont, the Medical Ess	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's U	sual Occupation work done during most of w	vorking 16b	Kind of Business/I	DLACIC ndustry
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, tra M	To Be C	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Ty	ndersor	19b. Mailing Addre	18. Mother's N	lame (First, Middle, Maid 900 f Bural Boute Number Cit	Inder	SOM in Code)
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Baltir	permit. Page Department of Important: If sny injury of once.		21. Signature of Funeral Service Licens	Spindy	22. Name HOS P	and Address of Facility	Nashing Carroll	ton Ad	Newfist
	Physician /Medical Examiner		23a. Parf1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of the death	ere Pe	e matur 7	lac or respiratory arrest,		Approximate Interval Between Onset and Death 2204
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of the consequence of t					
.O. Box 6	the death certifica y the attending phiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	I death 3 Ectopic			23d. Date of deli	νθry Day Year
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DIVI	i ii te	cal Certification:	3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Certifying Phy 2 Medical Exemi	28e. Place of Injury - At he building, etc. (Specify sician: To the best of my kno	wledge, death occurr	ed at the time, date and pla	28f. Location (Street City or Town, St	a(s) and manner as	stated
)	To the Hospital within 24 hours a To the Funeral C completely filled i	Medical	29b. Signature and title of certifier	ner: On the basis of examina and manner stated.		29c. License number		Date signed (Month	
-	, Bit	ite	30. Name and address of person who co	pmpleted cause of death (Item	610 60	irroli A	re + 46	30 Taker	ra lak, mD

			1 = For State Registrar	State of M	1aryland		artmen rtificat			nd Me	ental H	ygien Reg. N	20	05	331	33
	Physic /Medi		1. Decedent's Name (First, Middle, La Bakoly Andrian	,)						2. Date of D Month Septe:	D	^{ay} 28,	Year 2005	3. Time of D 0040	eath M
	Examir		4a. Facility Name (If not institution, given Montgomery General				4b. City.		Location of	Death			c. County	of Death	У	
	Funeral Director		5. Social Security Number 6. S 214–55–8995 1 Usual Residence of Decedent	ex	Age (In yrs. la		If Under Months		If Under 24 Hours	Min	B. Date of B (Month, D Nov •	irth ay, Year L8,	1957	9. Birthpl Count Madag	ace (State or I ry) gasgar	=oreigr
Q	d within 72 hours after death with the Maryland yane. Than "natural", or Itema 23a or 28a-f ehow tra Medical Evaminat must be notified at	Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 4005 Peppertree I 11. Marital Status 1 Never Married 2 Married	ane 12. Was Deceden Armed Forces 1 □ Yes 2	Silv		10f. Zip 209 Was Deced f Yes, spec	906 dent of Hi	spanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or Nican, etc.)	Mad	agasg	Vhat Count	ın Indian,	
-CL212	J within 72 jiene. r than "nai	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			16a. Dece (Give life.	dent's Usua kind of wo DO NOT us Lft Su	al Occupa rk done d se retired,	luring most o	of working	7		Specify. Kind of Bu ug St	MAI.	agasy	
ַ	2 should be filed and Mental Hygis is marked other aumatic event, the	To Be C	17. Father's Name (First, Middle, Last) Justin Rajaonar									olas	oa			
Бантоге, ма	permit. Peges 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		19a. Informant's Name/Relationship (Biclair Andrianar 20a. Method of Disposition 1	toandro/H	20b. Pla		Peppe sition (Nam natory or o	ertre	9) 0	e, S		Spr:	ing,	MD 2	20906	
Dail	permit. Departm Importa eny inju		21. Signature of Funeral Service Lice		м008	- Be	. Name an	d Addres	s of Facility	Robe	• Inc	Pum	phrey	7 Fun	eral Ho sin Ave	nme.
,00	Chysician /Medical /M	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each	Lymp s a conseque s a conseque	hoblas ence of): ence of):				ardide of	озріга (оту	311631,			Approximate Interval Betwe Onset and De	en ath
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		Registrar							Death			Reg. No. 2	000	7010
sicia	n	Decedent's Name (First, Mide			15120						Date of Dea Month	Day	Year	3. Time of Death
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amine	er	4a. Facility Name (If not institution of the Co	on, give s			P	40. City,	- /	Location of	,			unty of Death	
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		Usual Residence of Decedent												
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200	ρ	3₺ Widowed 4 □ Divorce		If Yes,	Give T r Dates:		1 🗆 Yes	2 . No	Specify:			Sp	pecify: B1	Lack
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		19a. Informant's Name/Relation					Mailing Address							
	J.	Sheila Adams 20a. Method of Disposition	/ Da	ughte			08 Aller				Landov ate			
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			For State Registrar	State of Mary		artment of					005	33135
			Decedent's Name (First, Middle, Last)			Timodio o	Dodin		2. Date of De	ath		3. Time of Death
	Physicia /Medic		CHARLENE CHAPPELL	AIKEN					Septen	nber	22 , 105	3:48 A M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town	, or Location	of Death			County of Death	
			Prince Georges Hos 5. Social Security Number 6. Sex		yrs. last birthday)	Che	verly	24 Hrs.	8. Date of Bir			
	Funeral Director			0.00	59 Yrs.	Months Day		Min.	(Month, Da	ıy, Year)	36 Miss	place (State or Foreign ntry)
	pu »		Usual Residence of Decedent 10a. State 10b. County	1100	c. City, Town or Lo				May Z	+, 17		
	within 72 hours after death with the Maryland ene. than "natural" or flems 23e or 28e-f show ha Medical Examinar must be notified at	tor	Maryland Prince Ge	1 .	Capital 1							10d. Inside City Limits 1 Yes 2 No
	n the	Director	10e. Street and Number			10f. Zip Code)			10g. Citiz	en of What Cou	ntry?
	23e c		1320 Dunbar Oaks Dr	ive		2074	¥3		τ	Jnite	d State	s
	er dea Items	Funerai		Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Ci	f Hispanic Or uban, Mexical	igin? (Spec n, Puerto R	cify Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White,	
336	urs aft	þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣No If Yes, Give Year or Dates:		1□Yes 2\XX	lo Specify:	:			Specify: B	1ack
2-0	hin 72 hore. B. "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Dece	dent's Usual Occ	cupation	et of workin			d of Business/In	
2	within ene. than "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)	St Of WORKIT	g		rd Univ	ersity entistry
d 2	e filed with al Hygiene. I other than vent, than		12th grade 17. Father's Name (First, Middle, Last)		_ Den	tal Assi		er's Name	(First, Middle,			
Maryland 21215-0036	nd 2 should be filed lith and Mental Hygi 27 is marked other r freumetic event,	To Be	Charles Underwood						Underw		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
lary	2 sho i and h is ma reume	· ·	19a. Informant's Name/Relationship (Type	· .	19b. Mailir	ng Address (Stree	oet and Numbe	er or Rural	Route Number	er, City or	Town, State, Zip	Code) 20743
	1 a lea		Abraham Aiken / Husl 20a. Method of Disposition		Ob. Place of Dispo	sition (Name of		DIIVE			ation - City or To	
Baltimore,			1 Burial Cremation 3 Ren 4 Donator 5 Other (Specify)		Washing	natory or other p		Son+28	2005			
alti	permit. Page Depertment I Importent: If any injury or once.		21. Signature of Funeral Service Licensee	11		2. Name and Add						eral Home
<u> </u>	8258		Jameeta -	ASON.		16 Kenn	edy ST	NW W	DC 200	11	101	.0101
Я			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the cause on each line.	death. Do not ent	er the mode of d	lying, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	THEROSCLE		RDIOVASC	CULAR E	IEART	DISEAS	SE		
Р	Examiner			Due to (or as a cor	nsequence or):							
	D ##	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):							
	and i-trans	Examine	that initiated events resulting in death) Last	Due to (or as a cor	rsequence of):					_		
8760,	rate be executed hysician and the buriai-transit	dical E		220 10 (0. 40 4 00.							1	
687	tificate ig phy as the	fedic	0	71-								
Вох	ath certific attending p for use as f	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pro		Ectopic pregnar	тсу			23	3d. Date of delive	
0.	the a	Physician/Me	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify)					Month	Day Year
۳.	that the dended	by Ph	Part II. Other significant conditions contri	buting to death but no	t resulting in the u	nderlying cause	given in Part I	ı.	23e. Did to	obacco us	e contribute to t	he cause of death?
ecords,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ed b							101	Yes 2□	lNo 3∏Prot	pably 4 Junknown
ecc	e law requ has been e 2 shoul	ompieted							24a. Was		prior to co	psy findings available mpletion of cause of
al R		O								rmed? 2 No	death?	2□ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	2 ER/Outpatier	nt 3 DOA)then		(Check only o		E011 - 10	
J Of		-	27. Man of Death	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. In	4 🗆 NU		Bd. Describe h		Other (Specif	y)
sior	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(IMONIA, Day 102	an injury		Yes 2	No				
Division	i Diffe	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (Sp	At home, farm, str oecify)	eet, factory, offic	6	28	Bf. Location (S City or Tox	Street and vn, State)	Number or Rura	al Route Number,
	spite ours nerel filled		29a. Certifier 1 Certifying Physic	ian: To the best of my	knowledge, deatl	n occurred at the	time, date an	nd place, ar	nd due to the	cause(s) a	ind manner as s	tated
	within 24 hos Vithin 24 h	edicai	(Check only 2 Medical Examine one)	On the basis of examination of the basis of th	mination and/or in	vestigation, in my	y opinion, dea	ith occurred	d at the time,	date and p	place, and due to	o the cause(s)
	within 2	Σ	29b. Signature and title of certifier	1001	- 25		nse number	700			signed (Month,	
	15/0	Į,	30. Name and address of person who com	lated aguas of days	(Itom 22a) T:=	Print)	0055	7 1	1	sep1	- mles	26 200)
	Type		SAVA DOS SUL	vester	3001 K	tos pital	Drin	ve, (for	5	mm!	26 2005
	Sta Registr		SEP 2 9 2005	32. Registrar's S	Signature					1)	7	

			1 - For State Registrar	State of Mary			alth and M	ental Hygie	ene , N2005	33136
	Physici /Medic		1. Decedent's Name (First, Middle, La: Grace Marie					2. Date of Death Month SEPT.	Day Year 26 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, give PENINSULA REGIONAL	street and number) Medical	untu	4b. City, Town, or L	ocation of Death		4c. County of Death	
34	Funeral Director		11/ a	ex 7. Age (In □ M 2 🛣 F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, Y 9/26/05	(ear) 9. Birth Cou Mar	place (State or Foreign ntry) yland
	Aaryiand show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic		Salisbu					10d. Inside City Limits 1 ☐ Yes 2 X No
	with the h	Direct	10e. Street and Number 1501 Iris Drive		Dailbou	10f. Zip Code 2180	4	10g	g. Citizen of What Cou USA	
036	o within 72 hours after death with the Maryland plene. I than "natural", or items 23s or 28s-f show the Marical Examiner must be motified a	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
1215-	within 72 jiene. r than "nai	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupati kind of work done dui DO NOT use retired)	on ring most of working	ng 16	Sb. Kind of Business/In	ndustry
land	should be filed ind Mental Hygis marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) Charles Bridde.	ll III		1	8. Mother's Name Maria	(First, Middle, Ma Joy Bowde	iden Sumame)	
	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Maria J. Baber/I	nother	150	l Iris Dr.			City or Town, State, Zi 21804	o Code)
Baltimore,	Pages 1 and ment of Healt ant: If Item 2 ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	nemoval hom State	Ob. Place of Dispo cemetery, cre Parsons	osition (Name of matory or other place) Cemetery			Salisbury,	
Balt	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Licente 12. A Control of Service 23a. Part 1. Enter the disease, or com	every (F)	9	01 Snow H	ill Rd.,	Salisbur	essional As Ty, MD 2180	ssociation 04
ħ	death certificate be executed e attending physician and act to use as the burial-transit d for use as the burial-transit	licai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	_	isequence of).	premo	ztunt	7		Interval Between Onset and Death
P.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
rds, P	The law requires that the ste has been signed by the page 2 should be detached.	ρ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	he cause of death?
		Completed							prior to co	opsy findings available impletion of cause of
	ding Physici h. After this cer funeral direc	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	of 28c. Injury a Work?	4 1 Nursing Hon	7	ce 6 Other (Speci	(y)
Division	P d in i	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office	2	Bf. Location (Stree City or Town,	et and Number or Run State)	al Route Number,
	To the Mospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of examination of manner stated.	r knowledge, deat mination and/or in	h occurred at the time, vestigation, in my opin	date and place, a lion, death occurre	nd due to the caused at the time, date	se(s) and manner as s a and place, and due t	stated. to the cause(s)
	To the withing the	M	29b. Signature and title of certifier X M. SW	una		29c. License n	335L	29d	. Date signed (Month, 09/26	Day, Year)
		L Vi	30. Name and address of person who MINAKSHI SUKUM	an m. 10	(Item 23a) (Type,	Print)	Salishi	nu Md	09/26	1
	Sta Registi		31. Date filed (Month Cay Year)	32. Sistrar's S		have,		/		

			1- For State of Mary Registrar		artment of I			ne No.2005	33137
	Physici		Decedent's Name (First, Middle, Last)	Ba	bhio	ton	2. Date of Death Month	Day Year	3. Time of Death
, ,	/Medio Examir		4a. Facility Name (If not institution, give street and number), The Johns Hapkins Hospital	/	Baltin	or Location of Death	City	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (Ir 577-56-9750 1 □ M 2 □ F 62 1 □ M 2	n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo Jan. 25, 1	943 Wash	hplace (State or Foreign unity) ington, DC
	e Maryland e-f ehow lifted at	ctor	10a. State	Chevy Cl					10d. tnside City Limits P☐ Yes 2 ☐ No
	th with th	ai Director	10e. Street and Number 3408 Turner Lane		10f. Zip Code	20815	10g.	Citizen of What Co	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show maportant: If Item 27 is marked other than "natural", or Items 23e or 28e-f show appoint to a proper traumatic avant, Ite Medical Erapidar road be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ff	Vas Decedent of 1 Yes, specify Cub	Hispanic Origin? (S lan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036	within 72 ho ene. then "natur ie Medicel	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give)	DO NOT use retire	during most of wor	rking	b. Kind of Business/	•
and 2	be filed stal Hygi sd other avant, I	Be	17. Father's Name (First, Middle, Last) William F. Babbington, Sr.	Dick	ccricar	18. Mother's Nan	ne (First, Middle, Mai	iden Sumame)	Navy
laryla	should and Men is marks	٦	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree		rie J. McDe		Tip Code)
Baltimore, M	Pages 1 and 2 nent of Health a int: If Item 27 is		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos	sition (Name of natory or other pla	ce) Sept	ember	c. Location - City or	
Baltir	permit. P Departme Importan any injur once.		21. Signature of Funeral Service (Joensee)	22.	. Name and Addr	ess of Facility De	Vol Funera N.W. Wa		
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition	death. Do not ente	er the mode of dy	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	J.	resulting in death) Due to (or as a co	posequence of):	ympho	cytic 1	Leuke	nla	11 years
8760,	cate be executed physicien end the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co						
O. Box 6	ath certifi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of deliment	very Day Year
Δ.	w requires that the de been signed by the e should be detached t	þ	Part fl. Other significant conditions contributing to death but no	ot resulting in the un	derlying cause gr	ven in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to	the cause of death?
Division of Vital Records,	n: The law requicete hes been r, page 2 shoul	Completed					24a. Was an autopsy performed	prior to o death?	topsy findings available completion of cause of
f Vit	hysician his certif I director	To Be		2 ER/Outpatient	t 3□ DOA Ott	105	th (Check only one) ome 5 Residence	a 6 ☐Other (Spec	infy)
ision o	To the Hospital or Attending Physician: The within 24 burs either death. To the Funaral Director: After this certificete his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Maturaf 2 Accident 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Ye			ryat rk? Yes 2 □ No	28d. Describe how i	njury occurred t and Number or Rui	ral Boute Number
Ö.	spital or A nours efter naral Dire		4 Homicide building, etc. (S	Specify)	occurred at the ti	me, date and place	City or Town, S	(ate)	stated
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated. 29b. Signature and title of certifier	amination and/or inv	estigation, in my	ppinion, death occu	rred at the time, date	and place, and due Date signed (Month	to the cause(s)
	10		Peter S Beginn Medical L	octor	Res	-00C) Sep	tember 29	2005
	Sta	te	30. Name and address of person who completed cause of death Peter Benjamin, The Johns Harkins 31. Date filed (Month, Day, Year) 32. Registrar's:	(Item 23a) (Type, F Shuspital C Signature	MI	Wolfe S	treet Balti	more, Mar	yland 2128'
4	Registr		SEP 2 8 2005	St April	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2, perME, G8/48_10/13/05_TT
State of Maryland / Department of Health and Mental Hygiene O. O. O.

Distriction		1. Decedent's Name (First, Middle, La	st)		Cei			2. Date of Dea		01 /	3. Time of Dea
Physicia /Medic		Nora Teresa Ba	usch					Month SEPTEMBI	Day	24 Year 6 200	0400 A
Examin		4a. Facility Name (If not institution, giv		ber)		4b. City, Town, o	r Location of Death		4c. C	ounty of Dea	th
	- 4	SUBURBAN HOSPITAI	1			BETHESD	A		MON	TGOMER	ĽΥ
, Funeral		5. Social Security Number 6. S	ex 7 □ M 2 13tF	. Age (In yrs. I	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	Year)	Co	thplace (State or Fo buntry) shington,
Director	1	216-82-0607 Usual Residence of Decedent		01				March 1	0, 19	724 Was	surngton,
/land		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Li
Man	to	Maryland Howai	-đ	Clar	ksvill	٩					1 Tes 2
r 28s	rec	10e. Street and Number	<u> </u>	10101	710 V 111	10f. Zip Code			10g. Citize	n of What Co	ountry?
23a o	a D	13131 Triadelphi	a Mill H	Road		21029			τ	JSA	
dea	Funeral Director	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14	Race - Ame	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Engineer must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dat	No No		1 ☐ Yes 2 ☑ No	Specify:	, , , , , , , , , , , , , , , , , , ,		pecify: Wh:	
72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup	pation	kina	16b. Kind	of Business	/Industry
thin 7	ple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retire	during most of work d)	(ing			
er th	5	12			Home	maker				Home	
tal Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ie (First, Middle,	Maiden Si	umame)	
Men arke	2	Karl Cussler						resa Br			
and and lam		19a. Informant's Name/Relationship (Туре, Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numbe	r, City or T	Town, State, .	Zip Code)
and Balth n 27 ner tr		Jeannie Muth/ Day	ıghter								le, MD 21
Pages 1		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Idle	_	sition (Name of matory or other place even Cemete	- T-			er Spri	Town, State
Departm Departm Importa any inju		21. Signature of Funeral Service Lice	nsee	***	22 F1	Name and Addre	collins	Funeral	Home	Inc	g, MD 209
X	\dashv	23a. Part1. Enter the disease, or com		used the death						phriid	Approximate Interval Between
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 at 1, 1 and 2 to minare cause. Each of leader listed without	b	pres a consequence as a consequence	00.00.000	IES					Onset and Deat
nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	cDue to (o	r as a conseq	uence of);				_	-	
ate be exe hysician at the burial-t	dical Ex	resulting in death) Last	d								
ath ce attendii for use	ysician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		th 2 ☐ Feta Int at time of d	Ideath 3□	Ectopic pregnancy	1		230	d. Date of de Month	livery Day Year
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ng Physician: The law requires that the death certificate has been signed by the attending neral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Feta nt at time of di wn ath but not rest	ER/Outpatier 28b. Time o	Other (specify) Inderlying cause gruent It 3 DOA Other (specify) It 3 DOA Other (specify)	26. Place of Dea	24a. Was autop perio 192 Yes th (Check only o ome 5 Residue) 28d. Describe h	an sy med? 2 No ne) lence 6 [ow injury or	Month a contribute to No 3 Pri 24b. Were an prior to death? Yes Other (Spe	Day Year of the cause of death robably 4 Dunkn utopsy findings avai completion of cause s 2 No
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** September 26, 2005 5:39p Donna Jean Bergtold /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year Feb 22, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F Country) Michigan 1932 73 Director 522-46-6761 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show injury of other treumatic svent. The Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Montgomery Village Maryland | Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 20886 United States Items 23a 9933 Dellcastle Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fashion Consultant Retail Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hazel Cook Harry T. Dent ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other tree once. 9933 Dellcastle Road, Montgomery Village, MD 20886 David Bergtold (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/27/2005 Alexandria, Virginia 22 Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee Gaithersburg, MD Mall 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MyocARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) 3 class Physician Acute /Medical ue to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No for 5 Other (specify) 4☐ Pregnant at time of death P.O. 9 Unknown 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown PIRATORY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Heart 2□ No omplete 2 1 No 1 Yes certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA Certification: To this After this funeral o 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. unerel Director: A 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours af 1 Craifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification 0 September 36,2005 D a6443 ken 30. Name and address from who completed cause of death (Item 23a) (Type, Print) 15225 Shuly Grove ROAD ROCKVILLE MARYLAND 2085 GREGORY He 31. Date filed (Month, Day, Year) shen

Registrar DHMH 17 Rev 1/2001

State

SEP 28

2005

32. Registrar's Signature

BARNE -

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. 2005	33140
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	22
				more
	Funeral Director		1 M 2F 96 Months Days Hours Min. (Month, Day, Year) C	rthplace (State or Foreign ountry) acuse, NY
	ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	e Mary Se-f sh	ctor	MD Baltimore Pikesville	1 ☐ Yes 2½ No
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What C	
	death ms 23	nera	1830 Reisterstown Road 21208 United Sta 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?) 14. Race - Armed Fixes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Armed Fixes, specify Cuban, Mexican, Puerto Rican, etc.)	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-1 show any injury ago, other traumatic event, the Modical Examination and the routilist at once.	by Fur	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give 2 No If Yes, Give 2 Year or Dates: 1 Yes 2 No Specify: Wh	
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Maryland	should be and Mental I marked o umatic eve	To B	Samuel Burman Esther Shamus	
Mar	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Lawrence Burman, Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3112 Gracefield Road Silver Spring MD 20	
ore,	of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)	Town, State
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Ba	permit. Departr Importe any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funera 11800 New Hampshire Avenue Silver Sp	
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Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 4 Hornicide 3 Suicide 4 Hornicide 3 Suicide 4 Hornicide 4 Suicide 4 Suicide 5 Suicide 5 Suicide 6 Suicide 6 Suicide 6 Suicide 6 Suicide 7 Suicide 7 Suicide 8 Suicide 8 Suicide 8 Suicide 9 Suicide	ıral Route Number,
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	To the Hospitel within 24 hours To the Funerel completely filled	Medical	(Check only one) 21 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated and manner stated.	to the cause(s)
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	<u>ر</u>		30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Christine, Kajubi, MAD.	1
	Sto	to	NWHE 5401 Old Court Koad Kandall Stwon Mary lan	0
	Sta Registr	. 5	with the second of the second	

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** err 224 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital aric Montgomery rakoma-If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number UNV 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. It a Medical Examinating that mailted at Washington 1 Yes 2 □ No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ervace, 20020 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filled within 72 hours after inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 25 No Baltimore, Maryland 21215-0036 þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -ant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin, Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washingt aibat Memudu on Adventist HOSP 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Adv. Hos * 4 ☐ Donation 5 ☐ Other (Specify) Washington Advergist Hosp 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7600 Canolitue, Takoma-panc due Valloindu 23a. Part1. El ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician + matri disease or condition resulting in death) /Medical Due to (or as a consequence of) how Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending 1 Natural 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0006117 Joanne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oner Greense Cerry 2005 Agriculture 31. Date filed (Month, Day, Year) State Registrar

			For State Registrer 1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Depa	artment o	of Hea	lth ar ath	d Mental F	Reg. No	/ 11 11 5	33142
	Physici /Medic Examir	al	Irene Raak Biller 4a. Facility Name (If not institution, give s			4b. City, Tov	wn, or Loca	ation of [Septe	mber	28,2005 County of Dear	6:30 A M
	Funeral Director		060-32-4194	M STYE	last birthday) 71 Yrs.	Elkt. If Under 1 Y Months D	ear If C	Inder 24 ours	Min. (Month.	Dav. Year.	Cecil 9. Bin 7,1913 E	inplace (State or Foreign buntry) Stonia
	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23e or 28e-f show any nivry or other treumetic event. The Medical Exprend must be rutified at ance.	Funeral Director	Usual Residence of Decedent 10a. State	12. Was Decedent Ever in U	ity, Town or Lo	Sun 101. Zip Co 219	11	nic Origin	? (Specify Yes or uerto Rican, etc.)	us	14. Race - Ame	rican Indian,
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Baltimore, Ma	Pages 1 and 2 tment of Health a tent: If item 27 is jury or other tree		Udo Schreiber 20a. Method of Disposition 1 (X)Burial 2 (X)Fremation 3 (A) 4 (Donation 5 (Other (Specify))	emoval from State	Place of Dispo cemetery, crer DENEZET	sition (Name of matory or other Cemeto	of r place) ery	10	Rising S Date 3-2005	20c. L	ocation - City or Sing Sun	Town, State
Bal	permit Depin Impor any in 20028.		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea	<u> </u>	11 S. 9	Queen	Str	R.T. Foar Leet, Ris Indiac or respiratory	ing S	ieral Ho Sun, MD	me, P.A. 21911 Approximate Interval Between Ogset and Death
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of	ding Phys J. After this funeral dir	ation; To B	examiner?	ospital: 1 npatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Othor	☐ Nursi	ng Home 5 Re 28d. Describ	sidence		cify)
Division	5 in the 0	I Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	ity) 			to and a	City or T	own, State	ə)	Iral Route Number,
)	To the Hospitel within 24 hours a To the Funerel Completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examir 29b. Signature and title of certifier	ician: To the best of my kn er: On the basis of examin and manner stated.	ation and/or in	vestigation, in	my opinion	nber	occurred at the tim	e, date an	and manner as diplace, and due signed (Month	to the cause(s)
	6		30. Name and address of person who co	L Waren .	Risin	Print) Sui		40	SAIL		-10010	
	Sta Regista		31. Date filed (Month, Day, Year) SEP 3 0 2005	22. Registrar's Sign	ature	K)						

			1 - For Stata Registrar	State of M	aryland		artment o			nd Me		giene	005	33143
			Decedent's Name (First, Middle, La.	st)						1	2. Date of Dea		Year	3. Time of Death
	Physici /Medic			JANIS I	MAY BI	IZZI	ARD				SEPT.	25,	2005	3:48 P M
	Examin		4a. Facility Name (If not institution, giv				4b. City, Tov						unty of Dea	
			1847 OLD WESTM 5. Social Security Number 6. S		PIKE Age (In yrs. las	t hirthday)	WES	TMI	NSTI Under 2		8 Date of Birt		ARROI	Lithplace (State or Foreign
	Funeral Director			□M 2X)F	68				Hours	Min.	B. Date of Birt (Month, Day 3 / 1 8 /	y, Year)	Co	RYLAND
	D		Usual Residence of Decedent								97107	1,007		
	show	2	10a. State 10b. County MD CARROL	т	10c. City, T	I OWN OF LO								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number		MESI	LITING	10f. Zip Co	nde .				10g. Citizer	of What Co	
	3a or	10	1847 OLD WEST	MINSTER	PIKE			157				US		, .
	death ms 2	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13.			anic Origi	in? (Spec	ify Yes or No- ican, etc.)		Race - Ame	erican Indian,
9	or Ita		1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give		- 1	ires, specily 1⊡ Yes 2⊠		Specify:	rueito n	ican, eic.)		Black, Whit	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show issal Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates		16a Dave	dandle Herrel O						ecify: WH	
7	in 72 n "naf	Completed	15. Decedent's E	ide completed)		(Give	dent's Usual O kind of work o DO NOT use r	done durir	ing most o	of workin	g	I 6D. KING	of Business	rindustry
212	d within giene. er than "	omo	Elementary/Secondary (0-12)	College (1-4o	(5+)		TE	CLLE	R			BAI	NK	
	ba filed within 72 hours after death with the Marylar Ital Hygliene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle, Last,					18.			(First, Middle,		•	
<u>ya</u>	should ba	T _o		N E. OT						LEN		ZUGLI		
Maryland	2 2 2 3 2 3		19a. Informant's Name/Relationship (JOHN P. HARRIS	турө, Print) - NEPH							Route Numbe NTA Al			
	is 1 and of Health item 27 other to		20a. Method of Disposition	- 11111	20b. Plac	e of Dispo	sition (Name	of	51.	Da				2704 Town, State
E S	0 0		1 ☐ Burial 2 【 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specil	Removal from Stat b)	ALL C		natory`or othe Y CRE1		ON	9/2	6/05	SYKE	SVTL	LE, MD.
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licer	-	1						CHER			
_	89 = 29		11 Lay / Gry	-la	<i>F</i>						WEST		ER,	MD. 21157
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.		Α.	A						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Seve	en	1.1	brown		NSC	-01	m di	Sers		20 xvs.
в	Examiner		1	Due to (or a	as a consequer	rice of):								O
	يجع	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequer	nce of):								
	ocutad nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
90,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	I Ex	resulting in death) Last	Due to (or a	as a consequer	nce of):								
8760,	physic physic the t	dical	•	d										
Box 6	eath certific attending p	Physician/Med	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d	. Date of de	livery
	death e atte	Icia	in the past 12 months?	4□Pregnant	2 Fetal de at time of deat		Ectopic pregr Other (s <i>peci</i> i						Month	Day Year
P.0	at the de by the a	hys	9 □ Unknown	9□ Unknown								/		
	res that ignad b	by	Part II. Dther significant conditions of	ontributing to death	but not resulti	ing in the u	nderlying caus	se given ir	in Part I.		23e. Did to	_		o the cause of death?
Orc	w require been si should b	eted	COLV								-			
Records,	hast ge 2 s	Completed	K) P	0 (10 :					-		24a. Was autop perfo	rmed?	prior to death?	utopsy findings available completion of cause of
	rician: The certificate h rector, page	e Co	25. Was case referred to medical	W. M.	INS			26	6 Plane	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2 1 No
>	ysicis is cert direct	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 EF	R/Outpatier	it 3 DOA	Othor			e 5 Resid		Other (Spe	cify)
n of	ding Ph h. After th funeral		27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28 Day Year)	8b. Time of	28c.	Injury at Work?		28	3d. Describe h	now injury o	courred	
Sio	or Attending Physician: ufer death. Director: After this certifics in by the funeral director.	catl	2 Accident investigatio	n			М		2 🗆 N		26 1 10 10	21		10 11
Division	or At after of Direction by	Certification:	4 Homicide determined	286. Place of I	etc. (Specify)	e, rarm, str	eet, factory, of	ffice		20	City or Tox		umber or At	ural Route Number,
_	spital			ysician: To the bes										
	To tha Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	minar: On the basis and manner:	of examination stated.	n and/or in	vestigation, in	my opinio	ion, death	occurre	d at the time,	date and pla	ice, and due	to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	1111	MO		29c. Li	icense nu	- 0	9	9		_	h, Day, Year)
	15		P YUY	2009	/ / /			1)	92	> 1) -	0 1	- 64	- 20051
	M10		30. Name and address of person who PHILIP J. RUZ	completed cause of				את יד	R _ #	34 - 1	WESTMI	NSTE	R. МІ	D. 21158
	Sta	ite ²	31. Date filed (Month, Day, Year)	32. Regi	trar's Signatur	re			- - y 11	/ '			111	21,30
	Registi		SEP 2 7	2005	neve .	K.	book	•						

/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Box 68760 be detached O Division of Vital Records, P. should page 2 s certificate this After thi death. Il Director: A filled in by within 24 hours after To the Funeral Dire Hospitel the

Funeral

Director

or 28a-f show

Items 23a r death

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or other treumatic event, the Mudical Examiner must be notified at

filed within 72 hours after

Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural",

permit. Page Department of Important: If eny injury or once.

Physician

Maryland 21215-0036

Baltimore,

State Registrar

6

ROINTAN 31. Date filed (Month, Day, Year) SEP 3 0 2005

29b. Signature and title of certifier

FARAHIFAR M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

29c. License number

D 43 446 Septe 980/ Geogra Ave Snit 3-41

29d. Date signed (Month, Day, Year)

September 30, 2005

MO 20902

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** John 9 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number, Examiner 5 Prince Georges Hehal Ft. Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1920 9. Birthplace (State or Foreign Country)
Bedford, Va. 5. Social Security Numba 7. Age (In yrs. last birthday) **Funeral** 12 M 2□F 85 230-12-8068 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State al Hygiene. cither than "naturel", or Itame 23e or 28a-f ehow vent, the Medical Examinar must be notified at 1₺Yes 2□No Completed by Funeral Director Maryland Prince Georges Suitland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1818 Porter Ave. 20746 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after toent of Health and Mental Hygiene.
int: If Item 27 Ie marked other than "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Congressional Records Clerk Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alice Brown Henry R. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 le any injury or other trau 1818 Porter Ave. Suitland, Md. 20746 Ireatha R. Bell / Wife Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft.Lincoln Sept.30, 2005Brentwood, Md. * 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens Alexanders S Facility Pope Funeral Homes, P.A. 5538 Mariboro Pike/ Forestville, Md. Approximate Intervat Between Onset and Death Part1. Enfer the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Candio Varelan **Physician** heroscleroke /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No certificate has 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other. 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 29a. Certifier 1📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 1745365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livingston KS Hol, ft washing for MO 20766 richard Sidarons 31. Date filed (Month, Day, Year) State SEP 2 9 2005 Registrar

			For State	State of	Maryland / Dep	artment of H rtificate of I		, ,		00117		
		8	Registrar 1. Decedent's Name (First, Middle,	Last)				2. Date of Death	6000	3. Time of Death		
ľ	Physici /Medic				nett Burns	4. 05. 7.		September	24, 2005 4c. County of Death			
	Examin	er	4a. Facility Name (If not institution, s Southern Mary			4b. City, Town, or	Location of Death		eorges			
15.	- Funeral		5. Social Security Number 6		7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	1913 9. Birth	place (State or Foreign		
5	Director		579-34-6459 Usual Residence of Decedent	1 L M 2 M F	92 Yrs.			September	22, Nort	h Carolina		
	yland yland		10a. State 10b. County		10c. City, Town or Le	ocation				10d. fnside City Limits		
	e Mar	Director	District of Co	lumbia	Wash	ington				1X Yes 2 □ No		
	a or 2	Dire	10e. Street and Number 1918 "C" Street	ot N F		10f, Zip Code 200	ഹാ		United St	•		
	death ms 23	Funeral	11. Marital Status	12. Was Dece			lispanic Origin? (Spe an, Mexican, Puerto I		14. Race - Ameri	can Indian,		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic svent, the Madical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🗶 Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 X No	ir Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	Hican, etc.)	Black, White, Specify: B1	-		
215-0036	72 hou natura scal E	ted	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	ation during most of workii		16b. Kind of Business/Industry			
121	vithin ne. hsn "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	DO NOT use retired mestic En	d)		Domestic			
d 21	Hygie Hygie other t		8th grade 17. Father's Name (First, Middle, La	ist)	Во	mesere mi	<u> </u>	(First, Middle, Maid		10		
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic avant, the Mar	To Be	Andrew Arn	ett			Mary	Adlaide	Arnett			
/Jan	2 sho and f is ma		19a. Informant's Name/Relationship						ity or Town, State, Zip			
	s t and 2 of Health item 27 i		Edna Caro1 Burns 20a. Method of Disposition	s (Daught	20b. Place of Disp	osition (Name of	et,N.E.;	Washingto	n, D. C.	20002 own, State		
mor	0	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) National Harmony Memorial Park Landover, Mar										
Baltimore	permit. Page Department o Important: If any injury or once.		21 Signature of Funeral Service Li		V/_ 2	2. Name and Addres	ss of Facility	ny Mortic	ians, Inc			
4 4			23a, Part1. Enter the disease, or co	omplications that ca	aused the death. Do not en				hington,D	Approximate Interval Between		
	Physician		shock, or heart failure. List or Immediate Cause (Finaf disease or condition	ny one cause on e	Downs	NA 4				Onset and Death		
東	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	Land	b .	 -				
* .	- Autilities	ē	Sequentially list conditions, in any, leading to immediate	b. — Due to (U. as a consequence (ii).	n vune	rother	MM				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	down	Miller	, 1					
,00	cate be executed physician and the burial-transit	Exe	resulting in death) Last	Due to (or as a consequence of):							
8760,		dicai	•	d								
Вох 6	5 O 0	n/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	7			23d. Date of deliv	ery		
	0 0	by Physician/Me	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		ant at time of death 5	□Ectopic pregnancy □ Other (specify)	/		Month	Day Year		
s, P.O	requires that the leen signed by th hould be detache	y Ph	Part fl. Other significant condition	s contributing to de	eath but not resulting in the t	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?		
ords	w require been sig shoułd b		Dun	intra				1 ☐ Yes	2 X No 3 ☐ Prol	bably 4 ∐Unknown		
Records,		Completed				<u> </u>		24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of		
Vital		a	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2 X (Check only one)	No 1 ☐ Yes	2 L No		
of V	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 🗶 No		npatient 2 ER/Outpatie		4 🗆 Nursing Hor		e 6 ⊡Other (Speci	fy)		
ou c	ling After Tune	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		of Injury th, Day Year) 28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe how i	njury occurred			
Division	Atten	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At home, farm, st ng, etc. (Specify)			28f. Location (Stree City or Town, S	tion (Street and Number or Rural Route Number, or Town, State)			
	Hospital or 14 hours afte Funeral Dir tely filled in	Cer	X 0 - 446 in									
	a Hos 24 ho s Fun letely f	edical	29a. Certifier 1 Certifying (Check only one) 1 Medicaf E	xaminer: On the ba	best of my knowledge, dea asis of examination and/or in her stated.	in occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as s and place, and due t	o the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1	2 2	29c. Licens	e number	29d.	Date signed (Month,	Day, Year)		
) _			Mem &	ageumbe	e my	\mathcal{L}	23826.		4/24/05			
R	(5)		30. Name and address of person	d completed caus	be MD 770	Print) Old B	ranch A	Ve Clim	tm mo	20754		
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 9 2	005 K	egistrar's Signature	whi .						

ORIGINAL.

			For State Registrar	State of Ma	aryland / [rtment of H		ind Mental H	ygiene Reg. Ne		33	148	
	Physici	an	1. Decedent's Name (First, Middle, Last	,	-				Month	2. Date of Death 3. Time of Death				
	/Medic	al	Lora Marie 4a. Facility Name (If not institution, give	Bassf	ord	1	4b. City, Town, or	Location	Septe	mber	28,2 County of De		7:15M	
	Examin	er	14987 Bassford				Wald		Death		Char1			
	Funeral Director		5. Social Security Number 220-34-4136 6. Se	x 7. Ag ☐ M 2[X F	87	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. June	lirth Day Year) 17,1	918 Wa	irthplace (State Country) IShing	e or Foreign	
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Lo	cation					10d. Inside	City Limits	
	Maryli f sho	tor	MD Charle	s	Wa1								es 25 No	
	th the or 28a s.noti	irec	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What C	Country?		
	s 23a	ral	14987 Bassford				2060			US 11 Page				
36	within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y I If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba	spanic Orig n, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	10-	14. Race - Am Black, Wh Specify:			
	2 hou		15. Decedent's Edi	ucation	16a.	. Deced	ent's Usual Occupa	ation	a fi sua deina	16b. Ki	ind of Busines			
21	within 7 ene. than "r	Completed	(Specify only highest grad	College (1-4or s	5+) S.C	life. L	on Bus I)		Tre	ransportation			
2	Hyg than	e Coi	17. Father's Name (First, Middle, Last)		50	,110	JI DUS I		r's Name (First, Midd		-	Latio	11	
lau	be d al	To Be	William Perry	Tavman					a Mae Dodd					
Maryland 21215-0036	1 and 2 sho Health and 8m 27 Is ma thar trauma		19a. Informant's Name/Relationship (T					nd Numbe	r or Rural Route Num	ber, City o		, ,		
			Francis Bassfo 20a. Method of Disposition	rd,Jr./S	20h Place of	Dieno	cition (Nama of	1	Rd. Wald	1 00- 1-	antina Oltra	Taura Chata		
nor	Pages nent of I int: If its iry or o		Matriod of Disposition Matriod of Disposition 1 □ Burial 2 □ Cremation 3 □ Cremation 3 □ Cremation 5 □ Cremation 3 □ Crematio		Trini	ry, cren Lty	Memoria Memoria	1 1 Ga	r.10/1/0	5 Wa	aldorf	,Mary	1and	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	60	M00945	BI	Name and Addres	s of Facility	HOLS FUN	IERAL	HOME	,P.A.	20622	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only compediate Cause (Final	lications that caused	the death. Do	not ente	195 The right of the mode of dying	ee N	otch Rd.	Cha	rlott	e Hal	MT)	
	Physician		Immediate Cause (Final disease or condition	Conc	in de	C_r	Dear	1.	ralun	(2-	ė.	Onset an		
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):		0.0	(A)		Tr.	7.		
		e	Sequentially list conditions, if any, leading to immediate	0.	a consequence	of):	711915	150	11/15/16	671),	1	نارخي	
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	С								7		
, 0,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):								
8760,	phy:	dicai	•	d				Senion:	20000000					
.O. Box 6	at the death certific by the attending p tached for use as	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1							2	23d. Date of delivery Month Day Year				
Δ.	that the	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	n the ur	derlying cause give	n in Part I.	23e. Did	tobacco u	se contribute	to the cause o	f death?	
rds	w requires been sign should be								1	Yes 2	Юмо з□Р	Probably 4 [⊒Unknown	
Records,	2 2 2	ompleted							24a. Wa	opsy	prior to	autopsy finding completion of		
al H	(0)	O	-						1 ☐ Yes	formed? 2 X No	death? 1 ☐ Ye	s 2 No		
Vital	Physician: 1 this certificat ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatien	3□ DOA Othe		of Death (Check only sing Home 5 🕁 Re		S COther /Spe	ecity)	_	
n of		n: T	27. Manner of Death ↑ Natural 5 □ Pending	28a. Date of Inju (Month, Da	rv 28b.	Time of njury	28c. Injury Work		28d. Describe			oony		
Siol	Attending r death. sctor: After	catic	2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆 Y	res 2□N		(0)				
Division	Direction of	ertification	4 Homicide determined	building, et	ury - At nome, fa c. (Specify)	ırm, stre	et, factory, office			(Street and own, State)	d Number or F)	Rural Houte Nu	imber,	
	e Hospital or 124 hours afte a Funaral Dir letely filled in l	edicai C	29a. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis o and manner sta	f examination an	e, death	occurred at the tim estigation, in my op	e, date and inion, deat	d place, and due to the h occurred at the time	e cause(s) , date and	and manner a place, and du	is stated. se to the cause	∍ (s)	
	To the P within 24 To tha F complete	Me	29b. Signature and title of certifier	[]		7	29c. License	number		29d. Dat	e signed (Mon	nth, Day, Year)		
			co) conta	188/1	· MW		12.	506	1,50	Ç	1/52	101		
1	BB2,		30. Nam a see ddress of erson who c	ompleted cause of d	leath (Item 23a)	Туре, І	Print)	1	DUSY	2,00	77	16 Al	7	
	Sta	ite	31. Date filed (Monti Starp Year) 9 2	005 32. Resistr	ar's Signature	1 1	•	16	D VICT	11/6	1 01	000	/	
	Registr	ar	~=. ~ J Z	VUJ Flat	we &	1	rester							

			For Amend Item 1 - State Registrar	n 25 State of ME, G	/aryland / [85 1,01/1	Departm 8,06dh Certific	ent of F	lealth a Death	and Ment	al Hygien	^e 2005	33149	
			1. Decedent's Name (First, Middle	le, Last)						ate of Death		3. Time of Death	
	Physicia /Medic		Rosemary	Ann Cage	9				Sep	tember	27, 200	5 2:20 p M	
	Examin		4a. Facility Name (If not institution	n, give street and number	r)	4b. C	ity, Town, o	r Location o	of Death	4	c. County of Dea	th	
			Holy Cross Rel				urton			15	Montgom		
	Funeral		5. Social Security Number 579-52-5340	6. Sex 7. A 1 ☐ M 21X F	Age (In yrs. last bir 65	Yrs. Mont	hs Days	If Under Hours	Min (N	ate of Birth Month, Day, Yea Cil 23,	r) C	thplace (State or Foreign ountry)	
	Director		Usual Residence of Decedent						MPI	11 20,	1349 Wa	shington, DC	
	yland		10a. State 10b. County	/	10c. City, Tow	n or Location						10d. Inside City Limits	
	a-fsl	ctor	Maryland Prince	e George's	Нуа	attsvil	le					1 □Yes 2√2 No	
	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. C	Citizen of What C	ountry?	
	23a		9319 Lynmont				20783				USA		
336	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "netural", or items 23a or 28a-f show avent, if a Medical Everili or nate the notified a	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	s? d No	If Yes,	scedent of H specify Cuba s 2 🖾 No	lispanic Orig an, Mexican Specify:	gin? (Specify Y i, Puerto Rican	es or No- , etc.)	14. Race - Ame Black, Whi Specify: Wh:	te, etc.	
21215-0036	72 hor	ted		nt's Education	16a.	Decedent's U			t of working	16b.	/Industry		
2	within 7 ene. than "r	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-4or 5+) Manager							t of working				
21	e filed within at Hygiene. other then vent, the Me	Sol									tail Fu	rniture	
Maryland	be fill d oth d oth avan	Be	17. Father's Name (First, Middle,							t, Middle, Maide			
<u>\</u>	2 should be and Mental is marked o	은	Robert A. Ca	-	400		(2)			ia Hori			
Mar	12 st h and 7 is m traum	0.0	19a. Informant's Name/Relations Dolores T. Do								or Town, State,	Zip Code) and 20783	
	s 1 and f Healt itam2 other		20a. Method of Disposition		20b. Place o	f Disposition (Name of	1	Date	20c. l	Location - City or		
Baltimore,	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		nt Hillc	rest Men	prial (Gardens	Sept. 200	T 7.~~~	apolis,	Maryland	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as once.		21. Signature of Funeral Service	5 Ocale							me Inc er Sprin	ng, MD 20901	
i"			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause t only one cause on each	ed the death. Do line.	not enter the r	node of dyin	g, such as	cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death	
	Physician	a i	Immediate Cause (Final disease or condition	_a Spinal	Cord Com	ressi	on		11	<i>(</i>)		2 Months	
1	/Medical Examiner		resulting in death)		is a consequence				1	-			
		-	Sequentially list conditions, if any leading to immediate	b	tic Brea		cer		M			4 Years	
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury	4	10 11 00113041001100	Org.		11		4			
	icate be executed physician and s the burial-transit	хаг	that initiated events resulting in death) Last	c Due to (or a	is a consequence	of):		$-\psi$	/ W	Z-ICAL EXAN	AINER		
8760,	siciar siciar buri	dical		d					N APPROVED B	A WEDICKE			
9	ifficati g phy as the	Q I						ERTIFICATI	0/12/	Y MEDICAL EXAM			
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of de Month	livery Day Year		
<u>α</u>	that the post of t		Part II. Other significant conditi	ions contributing to death	but not resulting i	n the underlyir	ig cause giv	en in Part I.	2	3e. Did tobacco	use contribute to	the cause of death?	
rds	quires n sign ald be	d by	Hyperthyroid	ism						1 ☐ Yes	2 √ No 3□P	robably 4 Unknown	
Records,	The law requires that ate has been signed b page 2 should be deta	Completed							2	4a. Was an	24b. Were a	utopsy findings available completion of cause of	
æ	The la ate ha page 2	шо								autopsy performed? □ Yes 2□N	death?	completion of cause of	
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									cify)				
SO B ST													
27. Manner of Death Same of							ity or Town, Sta	and Number of Hi te)	ural Houle Number,				
							ue to the cause(s) and manner as	stated				
							the time, date ar	nd place, and due	to the cause(s)				
							h, Day, Year)						
	12		Find.	M/fu	mell.		D3	35996		Se	ptember	28, 2005	
	1~		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)							
			Linda M. Bur	crell, M.D.	2730 Uni	versit	y Blvc	440	00, Whea	aton, M	D 20902		
	Sta Registr		31. Date filed (Month, Day, Year, SEP 2 9	2005 32 Regis	strar's Signature	Aparti	1						

Thorpe Foster Caldwell Thorpe Foster Thorpe Foster Caldwell Thorpe Foster Thorpe Fo	ime of Death 0.55 M State or Foreign . side City Limits Yes 2 \(\) No					
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FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d.						
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27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)	dings available on of cause of					
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1 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	idings available on of cause of lo					
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and manner stated.	idings available on of cause of lo					
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John la J VIsidi 100 E. Carroll St. Salishury MD 21804						
State 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	e Number,					

151-01-0220

Physician /Medical **Examiner Funeral** Director Director

Reg. No. 2 U 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Year -HARLES - DWARD ORBIN 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . Regional Medical 5A4/364M MAL Wicomico PeninsulA Year If Under 2 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
3-24-24 Birthplace (State or Foreign Country) 1 M 2 □ F Hours Min 218-14-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Modical Examinar must be profitted at 10d. Inside City Limits 1 ☐ Yes 2 KNo WICOMICO ALISBURI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? OCEANCIT 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 IYes, Give Year or Dates: ARMY 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED 10 permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy, Important: If Item Z7 Is marked othe eny injury or other trauments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AUGHN BEATRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KOAD SAUSBURY MD 31804 BOSALIE P. 1312 - DLD OCEAN CORBIN - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) HEBRON MD 10 05 PRINGHIL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE SMITH F/H moul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** SHOCK /Medical Due to (or as a consequence of): 40 HRS. **Examiner** FAILURE ORGAN MULTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ASPIRATION NEUMONIA Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DYSPHAGIA 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MULTIPLE CVA'S 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 Yes 3 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 thpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063199. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMISHIN Vohra M.D. 100 E. CARRO. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND#24a&bperMD9/27/05, BW, No. Certificate of Death 1. Decedent's Name (First, Middle, Last)
Neil H. Campbell 2. Date of Death September 25, 2005 Physician /Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (If not institution, give street and number 4c. County of Death Prince George's Examiner Remaissance Gardens at Riderwood Village 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours 524-20-3262 79 Director Tennessee Sept.22,1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Modical Extrating roust be collined at any ones. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Silver Spring Prince George's Director 1 ☐ Yes 2 XNo 10e. Street and Number 3152 Gracefield Road, #316 10f. Zip Code 10g. Citizen of What Country? 20904 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Armed Forces... 1 X Yes 2 No. 1943–1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1948–1951 1 ☐ Yes 2 ☐ No Specify: 3 □Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Bureau of Elementary/Secondary (0-12) College (1-4or 5+) 5+ Investigation Special Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanfield Herman Annie Meyers ပ 19a. Informant's Name/Relationship (Type, Print) Helen M. Campbell -wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3152 Gracefield Rd., #316 Silver Spring, Md. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State Metropolitan Crematory 9/27/2005 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inaumorua **Physician** Spulation day /Medical Due to (or as a consequence of): Examiner 45phasen Goquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen a f) by Physiclan/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 1 🗌 Yes 2000 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 X Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical etely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date Igned (Month, Day, Year) DO043375 05 12 30. Name and address of per n who completed cause of death (Item 23a) (Type, Print) Karen Merritt, 3110 Gracefield Road Silver Spring, Maryland 20904 M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

			For State Registrar	State	of Maryla	nd / Depa <i>Ce</i>	artment o	f Hea of Dea	lth and ath	Mental Hy	giene Reg. No	200	15	33153
8.00	Physici /Medio	al	1. Decedent's Name (First, Middle, Robert	Foster	_ (Corr	igan			2. Date of D Month	eath Da	y yo	ar c	Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, Shady Grove Adv 5. Social Security Number 577-60-2849	•	lospita.	1 . last birthday) 91 Yrs.	Rocks If Under 1 Y Months Da	ille		s. 8. Date of B	Mointh	ontgome 9.	Birthplace Country)	(State or Foreign
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itame 23e or 28e-f ehow many njury or other traumatic event, the Medical Exam har must be notified at any njury or other traumatic event, the Medical Exam har must be notified at any or other traumatic event.	erai Director	10e. Street and Number 10404 Strathmore		ourt #4(10f. Zip Cod 20852		in Od-in 2 //	Specific Vec on N	Uni	tizen of What Lted St 14. Race - A	tates	
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	To the within 2.	Σ	29b. Signature and title of certifier	MD AT	tending		29c.	License	number	VIC.	29	d. Date signed	(Month, E	ay, Year)	
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			1 - For State Registrar	State of Maryland		artment of H tificate of L			iene _{eg. No.} 2005	33155		
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Henry S. Corvino					2. Date of Deat Month	Day Year	/		
	Examir	er	4a. Facility Name (If not institution, give si Calvert Manor Hea	· · · · · · · · · · · · · · · · · · ·	L	4b. City, Town, or		ith	4c. County of Deat	th		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		Risino If Under 1 Year Months Days	If Under 24 Hr. Hours Min	S. 8. Date of Birth	ate of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)			
	Director		Usual Residence of Decedent	M 2□F 9	1 Yrs.	Wiontins Days	Tiours	Septembe	r 2, 1914	NJ		
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
	he Ma 28a-f s	Director	MD Cecil	Ris	ing Su					1 ☐ Yes 2 🕱 No		
	3a or	i Dir	72 New Road			10f. Zip Code 21911		1	0g. Citizen of What Co USA	ountry?		
	r death	mera		Was Decedent Ever in U.: Armed Forces?	S. 13. \		ispanic Origin? (n. Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White			
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Dapartment of Heatth and Mental Hygiene. Important: If item 27 ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at 90ce.	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1/	Specify:	,	Specify: Wh			
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ylar	ould be Menta arked atic ev	ToB	Horace Corvino				Lucy	Marucci				
Mar	d 2 sho th and 7 la m traum		19a. Informant's Name/Relationship (Typ Robert Corvino/SC					Rural Route Number, City or Town, State, Zip Code) Sun MD 21911				
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Baltimore,	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	. Foar	d Funeral	Home.	P.A. R	ising Sun,	MaruEand		
Balt	Daparti Mport any inj		21. Senature of Funeral Service License	° /-	22	. Name and Addres	s of Facility R	.T. Foard	Funeral H	ome, P.A.		
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Vital		e Col	25. Was case referred to medical				26 Blace of De		No 1 Yes	2 No		
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Division of	l or Attandi after death Diractor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, str		Yes 2 □ No		eet and Number or Ru	ral Route Number,		
á	ital or A	Cert	4 Homicide	building, etc. (Specify)			City or Town	, State)			
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and manner stated. 29b. Signature and tifle of certifier 29b. Signature and tifle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thurk as, MV Starson's Market Chees appear							29	d. Date signed (Month	n, Day, Year)			
	,		> It farke	1, MY		111	5314	5	replem by	~ 29, 2005		
	6		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	- Ren	che su	peake	Horace	Elkten in		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure			•	1. 1. 1	7-9		
	Registr	ar	SEP 3 n 2005	con K A	harles							

			1 - For State Registrar	State of Ma	arylan			f Health a of Death	nd Mental H	giene (005	33156	
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	Examir Funeral	ier	University of Mar. 5. Social Security Number 6.	yland Mec Sex 7. Ag		Center	Ball If Under 1 Y	ear If Under 2	4 Hrs. 8. Date of B	irth	9. Birthpl	lace (State or Foreign	
4000	Director		193-60-6017 Usual Residence of Decedent 10a. State 10b. County	1□ M 2□XF	44	Yrs.			02-14	-1961	NEW	JERSEY ————————————————————————————————————	
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, the Maritsal Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:	NT A T7	1	Was Decedent f Yes, specify (1 ☐ Yes 2☐		n? (Specify Yes or N Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHITE		
21215-0036		Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12		i+)	(Give life. l	DO NOT use re	ne durina most o			Business/Ind		
Maryland 2		To Be C	17. Father's Name (First, Middle, La. WILLIAM MATTHEWS					18. Mother	s Name <i>(First, Middle</i> YN ZIMMERN	a, Maiden Suma AAN	faiden Sumame) N		
			19a. Informant's Name/Relationship SCOTT O. CULVER						or Rural Route Numi				
Baltimore,			20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		CE	lace of Dispo emetery, cren OAM CE	sition <i>(Name o</i> n <i>atory or other</i> METERY	place)	Date -30-2005	20c. Location	n - City or To		
Balti	permit. Departmit. Importa any inju		21. Signature of Foneral Service Lic	ensee Inen	lend	22	. Name and Ad	dress of Facility	BOUNDS FUNTEET, SALI	NERAL HO	OME, II	NC.	
8760,	Physician physic	resulting in death) Due to (or as a consequence of): Tracheo Esophageal fistula Due to (or as a consequence of): Due to (or as a consequence of): Luna and Thymus Cancer Due to (or as a consequence of): Compared the substantial of the											
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed refath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year		
	w requires that i been signed by should be deta	by	Part II. Other significant conditions	contributing to death b	ontributing to death but not resulting in the underlying cause given in Part I.						_	e cause of death? ably 4 Unknown	
al Records,	ding Physician: The law r. h. After this certificate has be funeral director, page 2 sh	Completed		300 (45					24a. Was auto perf 1 🗆 Yes		prior to com death?	osy findings available inpletion of cause of 2 No	
fVit	ysiciar ns certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 E	ER/Outpatien	t 3 DOA	Other	if Death Check only sing Home 5 - Res		ther (Specify)	
Division of Vital	ttending Pt death. :tor: After th		27. Manner of Ceath 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati		Y Year)	28b. Time of Injury		njury at Work? □ Yes 2 □ No		how injury occu	nred		
Divis	al or Atte s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hor c. (Specify	me, farm, str	eet, factory, off	се		(Street and Num wn, State)	nber or Rural	Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 X Certifying F	Physician: To the best of the basis of and manner sta	examinati ted.	ion and/or inv	estigation, in n	ny opinion, death	occurred at the time.	date and place	and due to	the cause(s)	
)	To the To the Complete	Me		Medical I	oct	23a) (Type,	29c. Lic AU4 Print)	ense number	315964 Yland	29d. Date sign 9/2	ed (Month, E	oay, Year)	
	Sta	te	HADDI SECKA, 1 31. Date filed (Month, Day, Year)	2005 32. Registra	MS ar's Signat	Bal	timor	e, Mar	yland:	21201			
4	Registr	-	SEP Z 8	2000	we.	H. A	melle						

CT
05-06598
Collingwood Uwanie State Registrar
7 - State Registrar

State of Maryland / Department of Health and M	Mental Hygien
Cartificate of Death	

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if itsm 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at another.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

Ye the Funerel Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar		Cen	tificate of	Death		Reg. No.					
	1. Decedent's Name (First, Middle, Last)			-				Date of Death 2 3.7mc of Death				
n al		larke Collin	gwood				Septe Septe	ember 28, 2005 4:15 AM				
r	4a. Facility Name (If not institution, give s Doctors Community			4b. City, Town, Lanham	or Location of	ounty of Dea ince (George's					
	5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year			8. Date of Bi	rth		thplace (State or Foreign ountry)		
	none 10	M 2 ☐ F 50	Yrs.	Months Days	Hours	Min.	(Month, Di	11, 19	955 Tr	ountry) inidad,WI		
	Usual Residence of Decedent		- T							1		
jo	10a. State 10b. County		City, Town or Loc haguanas		dad,WI					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
မို	10e. Street and Number	1.		10f. Zip Code				10g. Citize	n of What C	ountry?		
To Be Completed by Funeral Director	#3 Pierre street I	Lendore Vill	age	none				West Indies				
Jer	11. Marital Status	12. Was Decedent Ever in	U.S. 13. W	Vas Decedent of I	Hispanic Orig	in? (Spec	ify Yes or No	0- 14		- American Indian,		
È	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	l lf	Yes, specify Cub	an, Mexican,	, Puerto P	Rican, etc.)	Black, White, etc.				
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes ŽŽŽNo			Specify: Black					
ietec	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give k	ent's Usual Occu kind of work done OO NOT use retire	during most	of workin	g	16b. Kind of Business/Industry				
d Ho	Elementary/Secondary (0-12)	College (1-4or 5+)	Mana		,			Pri	ivate			
0	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)											
10 B	Anthony Clarke Marjorie Joseph											
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Collingwood (Daughter) #3 Pierre st. Lendore Village Chaguanas Trinidad, V											
	20a. Method of Disposition	r Town, State										
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Recity)	emoval from State C1	haัฐซืลหลัฐ atholic	Cemetery	y :	10/4/	/2005	Chagu	ıanas	Trinidad,WI		
	21. Signature of Funeral Service License	18	1,521,541	Name and Addr	ess of Facility	Fort	Lince	oln Fu	ıneral	Home		
	Buhard Thom	9 -12	34	Ol Blade	ensbur	g Roa	ad Bro	entwoo	od, ND	20722		
	23a. Part1. En the disease, or comilion shock, or heart failur. List only on Immediate Cause (Final disease or condition	cations that caused the de e cause on each line.	eath. Do not ente	Hemm				lere b	1/4.	Approximate Interval Between Onset and Death		
	Due to (a as a consequence of):											
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
ami	Cause (Disease or injury that initiated events c. resulting in death) Last											
VMedicai Examiner	Due to (or as a consequence of): d.											
ledic	IE EEMALE.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3	Ectopic pregnand Other (specify) _	:y			23	olivery Day Year			
hys	9 Unknown	9□ Unknown										
Medical Certification: To Be Completed by Physicia	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	derlying cause gi	ven in Part I.			tobacco use Yes 2 🗆		o the cause of death? robably 4 Junknown		
piete							24a. Was	an	24b. Were a	utopsy findings available completion of cause of		
Com							auto perfe 10 Yes	ormed? 2 \(\text{\text{No}}\)	death?	_		
Be	25. Was case referred to medical examiner?					of Death	Check only	one)				
0	1X Yes 2 No		ER/Outpatient	3 DOA			e 5 ☐ Res			ecify)		
tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	nyat ork?]Yes 2 □ N		8d. Describe	how injury	occurred			
Ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, stre						Number or R	lural Route Number,		
Cert	4 Homicide	building, etc. (Spe	icity)				City or To	wn, State)				
dicai	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	occurred at the t estigation, in my	ime, date and opinion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)		
Me	29b. Signature and title of certifier			29c. Licen	se number			29d. Date	signed (Mon	th, Day, Year)		
	1/1	UK h		OCME				Sonton	nhar o	0 2005		
	30. Name and address of person who co	impleted cause of death (II	tem 23a) (Type, F	e, Print)								
	THEODEREM, K		Mature	111	Penn S	tree	t Balt	imore,	, Mary	land 21201		
е	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature									

Registrar DHMH 17 Rev 1/2001

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	1 - For State Registrar	State of Marylan	d / Department o Certificate o		Mental Hy	/giene Reg. No.2005	3315
Physician	1. Decedent's Name (First, Middle, Las Joseph A.	Christopher I	II		2. Date of D. Month OCTOBE		3. Time of Death 8:46A.
	4a. Fecility Name (If not institution, give 10907 HESSONG BR	street and number)	4b. City, Tow	n, or Location of Dea		4c. County of De	ath
Funeral	5. Social Security Number 6. S		last birthday) If Under 1 Yo		8. Date of Bi	irth 9. B	rthplace (State or Fore CHINSY IVANIA
Director	Usual Residence of Decedent 10a. State 10b. County	10c Cit	/, Town or Location			,	10d. Inside City Lim
with the Maryl s or 28e-f eho be notified a	Maryland Frederi		rmont				1 ☐ Yes 2 🖾
th with the 23a or 2	10907 Hessong B	ridge Road	10f. Zip Coo 21			10g. Citizen of What C U.S.A.	country?
5-0036 72 hours after death with the Maryland natural; or items 23s or 28s-1 show alsal Exactions must be profitted at eted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	S. 13. Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or Note Rican, etc.)	o- 14. Race - Am Black, Wh Specify: W	ite, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itame 23s or 28s-1 show eny injury or other traumatic event, tra Medical Examinating has notified at once. To Be Completed by Funeral Director	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)		16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re General La		rking	16b. Kind of Busines	•
yland 2 suld be filed Mental Hygi mrked other atic event, I	17. Father's Name (First, Middle, Last) Joseph A.	Christopher		18. Mother's Na	me (First, Middle garet Ga	e, Maiden Surname)	
Mary nd 2 shc alth and 27 Is m	19a. Informant's Name/Relationship (7 Margaret Christop		19b. Mailing Address (Str. 428 Bellwood	eet and Number or R d Ave., Mo	ural Route Numb nroevil	per, City or Town, State, le, PA 1514	Zip Code) 6
imore, Pages 1 e nent of Hea nut: If item ury or othe	20a. Method of Disposition 14∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Cox	lace of Disposition (Name of amatery, crematory or other Shepherd Cameta	olace) ery Oct.	7, 2005	20c. Location - City o Monroevil	
Balt permit. Departr Imports eny inju	21. Signature of Funeral Service Licen	M00255	22, Name and Ad Keeney 6	dress of Facility and Basfor t. Church S	d PA Fu	neral Home derick, MD	21701
60, be exect ician and buriat-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	sophaged ence of Liver	Varices			
x 687 sertificate ding phy se as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	ncy death 3□Ectopic pregna	ncy		23d. Date of de Month	livery Day Year
rds, P.(Part II. Other significant conditions co	ntributing to death but not resu	lting in the underlying cause	given in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
The law requir			-				utopsy findings availat completion of cause o
of Vita hysicien his certifi il director	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ F	ER/Outpatient 3 □ DOA	0	ath (Check only o		
ding Phy After thi funeral	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Ir	njury at Vork?		dence 6 XOther (Spe how injury occurred	cny)SCENE
Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compl	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify,	ne, larm, street, factory, offic	Yes 2 No	28f. Location (: City or Tox	Street and Number or R wn, State)	ural Route Number,
To the Hospital within 24 hours e To the Funeral I completely filled Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	sician: To the best of my knowner: On the basis of examination and manner stated.	viedge, death occurred at the on and/or investigation, in m	e time, date and place y opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and due	s stated. to the cause(s)
ਵੁੱ≘ ਵੁੱਕੂ ਹ	29b. Signature and title of certifier		29c. Lice	ense number		29d. Date signed (Moni	h, Day, Year)
To To To To					1		
	30. Name and address of person who c		23a) (Type, Print)	C.M.E.		OCTOBER 2,2 E MARYLAND	

			For State	State of Marylar		ment of H		Mental Hygie	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Certii	icale of i	Death	2. Date of Death	Day Year	3.3 1.5.9 9. There of D. D. th.9
4	Physici /Medio	al	4a. Facility Name (If not institution, give s	tract and number)	41	h City Town or	Location of Deat	September	24, 2005 4c. County of Deat	11:15 P M
	Examir	er	WICOMICO NURSING HOME			SALISBURY	Location of Death	1	WICOMICO	n
	Funeral Director	ć	5. Social Security Number 6. Sex	M 2□ F 7. Age (In yrs.	last birthday) It	f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birtl Co	nplace (State or Foreign unity)
	Maryland a-f show	ctor	10a. State 10b. County MD Wiccom	10c. Cit	ry, Town or Locati	ion 1 Y LI				10d. Inside City Limits Yes 2 □ No
	h with the 23a or 28 31 be no	Funeral Director	10e, Street and Number 423 - Petrick	AVe		10f. Zip Code	801	10g	g. Citizen of What Co	untry?
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Itams 23e or 28e-f show event, the Medical Exeminar must be rediffed at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Noticed	I2. Was Decedent Ever in U Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: VA	If Ye	Decedent of H	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0036	hin 72 hou s. In "nature Medicel E	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent (Give kind life. DO		ation during most of wor f)	king	b. Kind of Business/	*
2	filed with Hygiene ither tha		17. Father's Name (First, Middle, Last)		Ma	SUN	19 Mothar's Nac	ne (First, Middle, Ma	SEIF &	n plaged
Maryland	be dall all all all all all all all all al	To Be	William Da	1.51			Core	Lelia	Far 1	(184)
Mary	S a a		19a. Informant's Name/Relationship (Type	oe, Print)	4	-20	and Number or Ru	ral Route Number, C	City or Town, State, 2	ip Code)
	is 1 and of Health itam 27 other tr		20a. Method of Disposition		Place of Disposition	on (Name of	-	Date 20	c. Location City or	02/80/ Fown, State
altimore,	Pages ment of I ant: If its		1 X Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Or south	11 Cers	etan 9/	30/05	Hebrar	mo
Balt	permit. Pag Department Important: any injury once.		21. Sign sure of Funeral Service License	Part) 9/-	ame and Addres	ss of Facility	Bennie;	Smith I	4 neval Home
	- 1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not enter th	he mode of dyin	g, such as cardiac	or respiratory arrest	s bury,	Approximate Interval 8 etween
ŗ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	FAILURE	TO THRI	VE .				Onset and Death
	Examiner			PNEUMNI	,					
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a conseq						
o	cate be executed oblysician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
8760	icate be physicia s the bu	dical	d	-						
.O. Box 6	ath certif ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 □Ect	topic pregnancy her (specify)			23d. Date of deli	very Day Year
۵.	res that the de signed by the a I be detached f		Part II. Other significant conditions con	tributing to death but not res	ulting in the under	rlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	w requires been sign should be	ted b	URINARY TRA	ct In	FECTION EMBOLIS	,		1 ☐ Yes	2□No 3□Pro	bably 4 Unknown
Vital Records,		Completed by	ANEMIA	INARY 6	EMBULIS	M		24a. Was an autopsy performer	prior to c	opsy findings available ompletion of cause of
Vita Vita	sician s certifi	o Be	25. as case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	EB/Outpationt	Othe		th Check onl one	e 6 □Other (Spec	76.1
Division of	ding After fune	ation: To	27. Manner of Death 1 Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Nursing n	28d. Describe how		ny)
Divis	pital or Attano ours after death aral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street,	factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	Hos Hos Fun iely	edical	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death oction and/or invest	curred at the tirr igation, in my op	ne, date and place pinion, death occu	and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
	To tha Hos within 24 h To tha Fun completely	Mec	29b. Signature and title of certifier	wild mainly stated.		29c. License	number	29d.	. Date signed (Month	, Day, Year)
٥	25 T		Mahaha	VT 1	no	D-00	060515		9/25/0	25
4	1		30. Name and address of person who com MAESHA THIMMARAYAPPA				SBURY, MD	21804	/ /	
	Sta Registr		31. Date filed (Month, Day, Year) 7 20	32. Paistrar's Signa						

2848 10/13/05 KBH Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 24-29 per Dr. State of Maryland / Department of Health and Mental Hygiene Reg. No 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:10 KM Baby Girl Dilutis 05 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Posedale
If Under 1 Year | If Under 24 Hrs. Franklin Square Hospital
5. Social Security Number 6. Sex 7. A Center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗑 F Director Sept 15, 2005 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location is marked other than "natural", or Items 23s or 28s-f show sumstic event, it a Musical Examinar musice notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Rosedale Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8733 Pulaski Hgwy #311 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No ff Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) none none none none permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other only injury or other traumatic event, page. unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rachel Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9000 Franklin Square Dr Baltimore, MD Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Puneral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prematurity disease or condition resulting in death) /Medical Examiner Labor & Delivery Preterm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ゴルム 名う 孔。タブ 名列 Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use confribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No neral Director: After this certificate has filled in by the funeral director, page 2 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1X Natural 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fun 1 Tes 2 No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - Af home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 (XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier AF23284124303 09 Franklin Square Hospital

State Registrar 31. Date filed (Month

women's

Pavillian

9000 Franklin Square Drive

BaltinLore,

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

M. Middleton, M.D.

inth. Day Year)

OCT 1 3 2005

2005

ADH ROBERT DAVIS O5-6588

586	3		For	State of M	Maryland / Dep			d Mental Hy	giene		
			1 - State Registrar		Ce	rtificate o	f Death		Reg. No.	2005	33161
	Physici	an	Decedent's Name (First, Middle, I					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al .	Robert William	Davis		4h Cibi Tour	, or Location of De	SEPTEM			1519 P ^M
1	Examin	er	4a. Fecility Name (If not institution, g 13436 FOUNTAIN			GERMANT		ain		ounty of Death	
	Funeral				ሷ Age (In yrs. last birthday	If Under 1 Yea	ar If Under 24 H	Irs. 8. Date of Bir	th	9. Birth	nolace (State or Foreign
	Director		218-54-6383	1 → M 2 □ F	54 Yrs.	Months Day	s Hours M	Dec. 1	y, Year) 5, 195		yland
	p .		Usual Residence of Decedent		1.0						
	arylar ehow	2	10a. State 10b. County		10c. City, Town or L					ĺ	10d. tnside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	Maryland Monto	gomery	Germant	OWN			10- Citi-	n of What Cou	
	with last	គ	13436 Fountain	Club Driv	Δ.	2087			TOG. CITIZE		iriti y r
	72 hours after death with the Maryland neturel; or items 23e or 28e-f ehow diget Examinar must be notified at	Funerai	11. Maritat Status	12. Was Deceder				(Specify Yes or No lerto Rican, etc.)	₎₋ 14	USA . Race - Amer	ican Indian,
(0	riter dea ritems	F	1 X Never Married 2 Married	Armed Forces				ierto Rican, etc.)	1	Black, White	
93	rei', c	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:	1 ☐ Yes 2 🛣 N	lo Specify:		S	pecifyWhit	e
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occ s kind of work dor	ne during most of v	working	16b. Kind	of Business/li	ndustry
121	within ene. then	g I	Elementary/Secondary (0-12)	College (1-4o	or 5+)	DO NOT use reti	ired)		_		
	be filed within 72 hours after death with the Marylan da Hygiene. da Hygiene. da Chiev then "neturel", or liema 23a or 28a-f ehow event, tre Medical Examinar must be rediffed at		17. Father's Name (First, Middle, La	1 st)	CI	erk	18. Mother's h	Name (First, Middle		ost Of	fice
an	d be ental	o Be	Leon R. Davis					lla Malir			
Maryland	2 should be and Menta is marked raumatic ev	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Number or	Rural Route Numb	er, City or 1	own, State, Zi	ip Code)
	es 1 end 2 should to of Heelth and Ment item 27 is marked r other traumatic		Leon R. Davis/	Father	312	2 Gracef	ield Roa	d. #CT-30	08. Si	lver S	pring, MD
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	□ Domoval from Sta	20b. Place of Disp		-()	Date pt. 30		ition - City or T	
Ĕ	G un in a position		4 Donation 5 Other (Spe		Gate of He	aven Cemet	tery	2005	Silve	r Spri	ng, Maryland
Baltimore,	permit. Peges 1 Department of H Important: If ite eny injury or ot		21. Signature of Funeral Service Lic	ensee	F	2. Name and Add	dress of Facility Collin	s Funeral	Home	InC	
_	0 □ = 0		Sames S	Dane	5	00 Unive	rsity Bl	vd, W, Si	lver	Spring	, MD 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	13 11	i line.	rer the mode of d	rying, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Cutt		ul m	The	nei	n		
	Examiner			Due to (or a	as a consequence of):						
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence of):						
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.							
ó,	e exe	Ë	resulting in death) Last	Due to (or a	as a consequence of):						
8760,	The law requires that the death certificate be executed wie has been signed by the eltending physicien end bege 2 should be detached for use as the burial-transit	dicai		d						-	
9 ×	ding p	0	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				20	15	
Вох	eath certifi ettending I for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	☐Ectopic pregnar			230	d. Date of delive Month	very Day Year
P.O.	t the de by tha tached	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		_ Cities (specify)					
٣.	s that ned b	by Pł	Part II. Other significant conditions	s contributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
Records,	w requires been sign should be							10	Yes 2	No 3∏Pro	bably 4 Unknown
တ္တ	law requass been 2 shoul	plet						24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
m.	The I	Completed						auto perio	omed?	death?	2□ No
Vital	Physician: The lithis certificate har director, pege	Be (25. Was case referred to medical examiner?	7			26. Place of [Death (Check only	ne)		
of \	Physic this or al dire	P	1X Yes 2 □ No	Hospital: 1 ☐ Inpa		nt 3 DOA		g Home 5 ☐ Resi			(y) SCENE
_	0 0 0	<u>ö</u>	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Ir (Month, L	njury 28b. Time Day Year) Injury	V		28d. Describe			neek
isic	or Attending after death. Director: After in by the fune	icat	2 Accident investigat 3 \$\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	be 390 Phase of	27/05 15:00 Injury - At home, farm, s		☐Yes 2 MNo				ral Route Number,
Division	after Direction by	Certification:	Homicide determine	building,	etc. (Specify)		26	City or To	wn, State) 🛭	34361	Fountern :
	spita nours nerai	aC	29a. Certifier 1 ☐ Certifying	Physician: To the be	st of my knowledge, dea	th occurred at the	time, date and pla	ace, and due to the	cause(s) ar	nd manner as	n, MD 20574
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fur	edicai	(Check only 2 Medical Ex	aminer: On the basis and manner	of examination and/or i	nvestigation, in m	y opinion, death of	ocurred at the time,	date and p	ace, and due	o the cause(s)
	To the To the Comp	Σ	29b. Signature and file of certifier	Ann	11		ense number			signed (Month	_
	8		XXXX	TUX		OC	CME	, i	SEPTEM	IBER 2	8, 2005
			30. Name and address of person wh	o completed cause o	}		NDC 24-	MILIONE :	(ADIT :	ATD Of	0.01
			31. Date filed (Month, Day, Year)				KEET, BAL	TIMORE, 1	IAKYLA	MD, 21	201
	Sta Registi		SEP 29	2005	He St. A.	arti					

			i icase i	State of Maryland /	Department of Health and	-	-	
			1 - For State Registrar AMEND #26 VERB		Certificate of Death	Reg. 1	711115	33162
	Physici	an	1. Decement's Name (First, Middle, Last)	David 45		2. Date of Death	Day 2 Year	3. Time of Death
2	/Medic	al	4a. Facility Name (If not institution, give si	treet and number)	4b. City, Town, or Location of Dea	september	4c. County of Death	3.727 **
	Examin	er	3316 DAK S	treet	Forestille		Prince (- eurges
	Funeral Director		5. Social Security Number 6. Sex 25 36-3195	M 200 F 7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24 Hr Months Days Hours Min			ace (State or Foreign
	pug *		Usual Residence of Decedent 10a. State , 10b. County	10c. City. To	own or Location		10	d. Inside City Limits
	he Maryis 28a-f sho	Director	MARY And Prince (- 10e. Street and Number	seorges For	estville 101. Zip Code	100	Citizen of What Countr	1 es 2 No
	23a or 2	rai Dir	3316 OAKS	Treet	20747	7	USF	9
920	d within 72 hours after death with the Maryland jene. r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be rediffed at	by Funerai	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - America Black, White, e	
21215-0036	n 72 ho "natur edicel	Completed	15. Decedent's Educ (Specify only highest grade	completed)	Ba. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO_NOT use retired).	orking 16b	. Kind of Business/Indu	ustry
212	d within giene. er than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Secretary	E	lementari	1 School
Maryland	should be filed or the state of	To Be (17. Father's Name (First, Middle, Last)	tolley	18. Motition's Na	ime (First, Middle, Maid In A RACh	e De Vi	lle
Mary	and and ls m		19a. Informant's Name/Relationship (Type	Daylo lang	9b. Mailing Address (Stree and Number of F	Tural Route Number, Cit	ty or T. wn, State, Zip o	Ode) 20772
	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place	of Disposition (Name of terry, crematory or other place)	Date 20c.	Location - City or Tow	vn, State
Baltimore,	Pag nent ant: I		1 Burial 2 Cremation 3 Re `4 Donation 5 Other (Specify)	Kes	surrection 9-	30-05 C	IN-NOW, M	ary land
Ball	permit. Pag Department important: any injury conce.		21. Signature Fundal Sofvice Licens	191	Adams Funeal	Home 8A	AGLASO	Mi) Zueve
Г			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	ations that gaused the death. De clause of each line.	o not enter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Alzhein	ners Disca	se		Onset and Death
b	/Medical Examiner			Due to (or as a consequence	ce of):			
	pe ils	iner	Sequentially list conditions, if any, leading to immediate cause. Enter this darking Cause (Disease or injury that initiated events	Due to (or as a consequence	ce of):			
Ć,	ate be executed hysicien and he burial-transit	Examiner	that initiated events c.	Due to (or as a consequence	ce of):		-	
3760,	ate be hysicie the bur	icai	d					
89 X	eath certificat attending phy I for use as th	/Med	IF FEMALE:	Bc. If yes, outcome of pregnancy			23d. Date of deliver	7
.O. Box	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ⊆Live birth 2 ⊟Fetal déa 4 ⊟Pregnant at time of death 9 ⊟Unknown				Day Y <i>e</i> ar
ls, P	res that signed b	by	Part II. Other significant conditions con	ributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
ecords,	w require been si should	leted				24a. Was an		sy findings available
$\mathbf{\alpha}$	The law cate has I	Completed				autopsy performed 1 Yes 2	? prior to com death?	npletion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			eath (Check only one)		
of	Phys r this ral dii	5	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ ER/6		Home 5 Residence		
ion	Attending I r death. sctor: After by the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	o. Time of 28c. Injury at Work? M 1 Yes 2 No			
Division	l or Attendate death Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specily)	farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	Hospita 4 hours Funeral ely fillec	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	4 0	29c. License number	29d.	Date signed (Month, D	Jay, Year)
			* Karne	MD	D00551	20 5	sept 20	2,2005
1	25		Name and address of person who por	mpleted cause of death (Item 23a	/	Que ST	= 5/c 3/r	Wash, De
	Sta	ate_	31. Date filed (Month, Day, Year)	32. Registrar's Signature		900	10 10	2009
	Regist		SEP 2 7 20	105 place l	- upone			

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1601 M John Dowlin septende /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Min 1**⊠**M 2□F Yrs. 1916 091-09-1348 89 14, Director March New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f ehow Examiner must be notilled at 1 ☐ Yes 2 XNo Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 102 Lakeview Drive United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify: Specify: 3 Widowed 4 Divorced white permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic event, the Mudical Exponse. "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Dowling Catherine Greenan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Lakeview Drive Anna olis, MD 21403 Muriel Dowling/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 9-27-05 Crownsville Vet. Cem. Crownsville, MD 21. Signary e if Fuzz ral Service Licen 22. Name and Address of Facility John M. Taylor Funeral Home, tt 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final 4:3. Physician Arterx discare Idrunary disease or condition resulting in death) /Medical Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien by Physician/Medical the th as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has page 2 autopsy performed? 1 Yes 2 No Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3L OA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of or Attending 1 HNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number and title of pertifier 29b. Signature September 23, 2003 051819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MGHCLS-MG/Ha 132 He 1/00 CT suite ZUI Annapolis MD 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Beulah Ε. Derrow September 23 2005 5:35a^M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Crofton Anne Arundel Crofton Convalescent and Rehab Ctr. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 25€ F Yrs. 1909 Virginia 95 Director 577-03-8481 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits ir than "natural", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at 1 XYes 2 □ No Director Edgewater Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 USA 196 Southdown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: White <u>გ</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper American Red Cross 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma C. Crismond George F. Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perrait. Pages 1 and 2 sh Department of Health and Important: if item 27 ie m any injury or other traum once. 196 Southdown Road, Edgewater, MD Gail Morauer/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 9/28/05 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclenotic Candio Vascular Diseas Physician disease or condition resulting in death) /Medical Examiner abe tes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 Yes Division of Vital Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Jursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Ceath 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural 2 Accident 5 Pending 2 🗌 No 1 🗌 Yes investigation 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 _0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D., 14300 Gallant Fox Lane, Ste. 222, Bowie, MD 20715 31. Date filed (Month, Day, Year) . Registrar's Signature State SEP 2 9 2005 Registrar

<i>O</i> .		1 State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar		ment of F ficate of			leg. No 200	5 3316
Physici /Medio Examir	cal	Julius Doug	glas street and number)		o. City, Town, o	r Location of Deat	Septeml	Day Ye 22, 20	
Funeral		Forestville Healt 5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If	Forest Under 1 Year onths Days	ville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Bay Aug. 8,	Year) 9.	e Georges Birthplace (State or Forei Country)
Director		251-28-3731 128 Usual Residence of Decedent 10a. State 10b. County		4 Yrs.	on		Aug. 8,	1921 Ora	angeburg, S. 10d. Inside City Limi
ith the Mar or 28e-f et	Director	Maryland Prince C		Forestvi	10f. Zip Code		1	0g. Citizen of What	P∑Yes 2□N
within 72 hours after deeth with the Maryland ene. then "netural", or iteme 23a or 28e-f ehow the Madical Examiner must be notified at	by Funeral Director	7420 Marlboro Pik 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 Eyes 2 □ No 12/ If Yes, Give Year or Dates: 11/2	30/42 If Ye	2074 Decedent of Hes, specify Cube		pecify Yes or No- o Rican, etc.)		States Imerican Indian, /hite, etc. Black
i within 72 hou liene. r then "netura the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation	16a. Decedent (Give kind life. DO	's Usual Occup d of work done NOT use retired SCaper	during most of wor	king	16b. Kind of Busine	
tould be filed Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Amos Douglas			_	Corrie	ne (First, Middle, i Shephar	d	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Patricia A. Kirk 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	/ Daughter		urwood in (Name of any or other place	Lane Ft.	Washing Date	ton, Md. 20c. Location - City The 1 tenhan	20744 or Town, State
permit. Departm Importa eny inju		21. Signature of Funeral Service Licens	ture you	22AN 55	exander 38 Mar			Homes, E	
Physician and // // // // // // // // // // // // //	Examiner	23a. Parth. Enter the disease, or complishock, or heart failure. List-onty or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the deal to cause on each line. Cardiopulm Due to (or as a consect of the	onary Fa puence of): rtery Di puence of): icular D	ilure sease		or respiratory arm	est,	Approximate Interval Between Onset and Death
The law requires that the death certificate be set has been signed by the attending physicis page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	I death 3 DEct	opic pregnancy ner (specify)			23d. Date of Month	delivery Day Year
quires that n signed b		Part II. Other significant conditions cor Myocardial Infa:		ulting in the under	tying cause giv	en in Part I.			o to the cause of death? Probably 4 2 Unknown
The law requirecete has been single 2 should I	Completed by	Hypertension Diabetes Melitus	3				24a. Was a autops perform	y prior t ned? death	
ysician: lis certifice director, I	To Be C	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} 2 \) \(\text{No} \) H	ospital: 1 Inpatient 2 I	ER/Outpatient 3	B DOA Oth		th Check only on		/es 2 □ No pecify)
Attending or death. octor: After by the fune	Certification;	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 3 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At his building, etc. (Specific	ome, farm, street,		vat ⟨? Yes 2 □No	28f. Location (St. City or Town	reet and Number or	Rural Route Number,
Hospita 4 hours Funerel ely fillec	Medical Ce	29a. Certifier (Check only one)	sician: To the best of my knoter: On the basis of examina and manner stated.	wledge, death occition and/or investig	curred at the tim gation, in my of	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	use(s) and manner ate and place, and c	as stated. lue to the cause(s)
To the within 2 To the complet	,	29b. Signature and title of certifier	M		29c. License D515			9d. Date signed <i>(Mo</i>	
1771	la	30. Name and address of person who co Bahram Pishdad		n 23a) (Type, Print Southern					

			Please I 1 - For State Registrar		ryland / Dep			Hygien	e 2005	33167
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Jan C 4a. Facility Name (If not institution, give s 10007 Goldenwood C	treet and number)	icia Di	XOU- ST 4b. City, Town, or Lo Upper Mar	EVENS Se	PT. a	Year 4,2005 Ic. County of Death rince Geo	
	Funeral Director		5. Social Security Number 6. Sex 579-64-2133	7. Age	(In yrs. last birthday, 58 Yrs.		Under 24 Hrs. 8. Date (Mon	of Birth th, Day, Yea 27, 1	9. Birth Cou 947 Wash	olece (State or Foreign ntry) Lngton, D.C.
	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 00ce.	Funerai Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo 10e. Street and Number 10007 Goldenwood	orge	10c. City, Town or L Upper Ma		2	"	Citizen of What Cou	•
980	ours after deet iral', or Items 2 Examinar mu	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent E- Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates:		If Yes, specify Cuban, I	anic Origin? (Specify Yes Mexican, Puerto Rican, el Specify:	tc.)	14. Race - Ameri Black, White, Specify: B1a	etc. ack
121215-0036	led within 72 h lygiene. her than *natu it, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupation is kind of work done during DO NOT use retired)	n ng most of working . Mother's Name (First, M	Fe	deral Gov	
ryland	12 should be fill and Mental H	To Be	17. Father's Name (First, Middle, Last) Tamlin Stevens 19a. Informant's Name/Relationship (Ty)	ne Print)	19b Mail		Gloria John:	son		o Code)
e, Ma	is 1 and 2 sl of Health an item 27 Is r other traur		Samuel Dixon/Spous 20a. Method of Disposition		10007	Goldenwoo	d Court;Uppe	er Mar		20772
Baltimore, Maryland	permit. Peges Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Harmony N		rkSept.30,20 of Facility Pope F1 5538 Ma Forest	uneral	ndover, N Homes o Pike MD, 207	
M. n.s.	Physician /Medical Examiner		23a. Part 1. Enter the discount of complete control of the control	BRE		ter the mode of dying, s	such as cardiac or respira			Approximate Interval Between Onset and Death
8760,	be executed sicien and burial-transit	Ilcal Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
O. Box 68	The law requires that the death certificate site has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	ery Day Year
rds, P.O.	quires that the signed by all be detacted	by	Part II. Other significant conditions con	tributing to death but	not resulting in the t	inderlying cause given i	n Part I. 23e	. Did tobacco	use contribute to t	he cause of death? pably 4XDUnknown
al Records,	: The law requir cate has been si page 2 should	Completed					24a	Was an autopsy performed?	prior to co	ppsy findings available impletion of cause of
Division of Vital	nding Physician: The th. : After this certificate hi funeral director, page	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 □ Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatie 28b. Time of 1njury	of 28c. Injury at Work?	5. Place of Death (Check 4 Nursing Home 5 2 28d. Des	Besidence	6 Other (Specification)	5y)
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office	28f. Loca City	ition (Street a or Town, Sta	and Number or Rura te)	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in I	edicai			examination and/or in		date and place, and due to on, death occurred at the	time, date a	nd place, and due to	o the cause(s)
0	To I with Com	M	. / /	mpleted cause of de	0 1 1 1		_		ptember Marylan	Day, Year) 229, 2005 1
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2005		S Signature See	e chive fi	4100	7081	+	

Albert R Eaton 05-06544 NJM

			1- State of Maryland State of Maryland	Certificate of Death	ı Mentai Hygie Reg.	21015 33168
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Ē	Physicia /Medic	al	Albert Rollins Eaton		September	
1.	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Death
100		¥ .	University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	Baltimore st birthday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	9. Birthplace (State or Foreign
35.1	Funeral Director		157M 2□ F	74 Yrs. Months Days Hours Mi	in. (Month, Day, Ye July 8 1	ear) Country)
	D J		Usuat Residence of Decedent	Town or Location		
	show	'n		estminster		10d. Inside City Limits 1 ☐ Yes 2 XNo
	the N	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	3a or		881 Snowfall Way	21157		USA
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Mudical Examinational be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ ☐ 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	ono mean, etc./	Specify: White
5-0	72 hc 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	working 168	b. Kind of Business/Industry
121	within ene. than "	Jdmo	Elementary/Secondary (0-12) College (1-4or 5+)	Welder		SCM Chemicals
d 2	filed withi Hygiene. other than		8 17. Father's Name (First, Middle, Last)		Name (First, Middle, Mai	
lan	should be and Mental marked o umatic eve	To Be	William Henry Eaton	Marie	Stephens	
ary	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the Mi		19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or		
	1 and 2 Health Ism 27 other tra		Wilma Faton/wife		estminster,	
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: If Itsm any injury or othe once.		1XZurial 2 Cremation 3 Removal from State	ce of Disposition (Name of netery, crematory or other place)		c. Location - City or Town, State
Ē	permit. Pages Depertment of Important: If II any injury or c		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			ykesville, MD
Ba	permit. Depertr Importa		21. Signature of the activities belong	Pritts Funeral Hor 412 Washington Ro		
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as card	fiac or respiratory arrest.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Multiple	injuries		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of):		
		9	Sequentially list conditions, b. Disa to for as a nonsequent	nna cf)		
	uted d ansit	Examiner	Sequentially list conditions, and the sequential sequen			
o,	ificate be executed g physicien and as the burial-transit		resulting in death) Last Due to (or as a conseque	nce of):		
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_	± 00 mi		IF FEMALE:			
Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of the past 12 months?	leath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Ö	res that the de signed by the a be detached f	yslo	1 Yes 2 No 9 Unknown	3 Cities (specify)		
Δ.	s that ned b	by Pr	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	w require been sig should b				1 ☐ Yes	2 No 3 Probably 4 Unknown
900	e law requ has been je 2 shouk	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Records,		Completed			perförme 1 ☐ Yes 2 🗓	d? death?
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	Death (Check only one)	
of	Phys this al dii	. To	27. Manner of Death 28a. Date of Injury 2	R/Outpatient 3 DOA 4 Nursing	g Home 5 Residence	
OU	iding Ph th. : After th s funeral	tlon	1 ☐ Natural 5 ☐ Pending (Month, Day Year) 2 🕅 Accident investigation 🦪 -Z.1 - O. ☐	Injury Work? 8:0 A M 1 N Yes 2 No	Subject for	ell about 12 feet mito
Division	Atter r dea ector by the	Ifica	a Format S C Could not be	ne, farm, street, factory, office	28f. Location (Stree	et and Number or Rural Route Number,
Ö	tel or rs afte el Dir ed in	Certification:		iare house	Belcamp.	Harford mD
	To the Hospitel or Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.			
		ž	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
	MIL		my hu, mis	OCME	Se	ptember, 26, 2005
	7		30. Name and address of person who completed cause of death (Item 2	111 Penn Stree	et Baltimo	re, Maryland 21201
3. 48° 3	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 7 2005	& Sperk		

			1 - For State Registrar	Item 21 per	Marviand / Dep FH,G848,10/J	artment of Ho 13405dhb rtificate of L	ealth and M Death	ental Hyg	iene eg. N2 0 0	5 33169
	Physici	an	1. Decedent's Name (First, A					2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic	cal	Anna	Mary Ett		AL City Town on		Septembe	er 25,200	
	Examir	ner	4a. Facility Name (If not institute 1146 Chrome		oer)	4b. City, Town, or	tsville		Harfor	
	Funeral		5. Social Security Number		. Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
	Director		217-01-9927 Usual Residence of Deceder	1 □ M 2 X F	87 Yrs.	Months Days	Hours Min.	(Month, Day) 08/26/1	rear)	Country)
Aarylan	Show	ō	MD 10b. Co	arford	10c. City, Town or L	ctsville				10d. Inside City Limits 1 ☐ Yes 2 X No
the N	28s-	Director	10e. Street and Number		Julie	10f. Zip Code		1	0g. Citizen of Wha	
with	3a or	0	1146 Chrome	Hill Road		21084			US	,.
5-0036 72 hours after death with the Maryland	nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23e or 28s-f show or other traumatic event, the Medical Example in the Italian at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐	12. Was Deced Armed Ford Married 1 Yes 2	ent Ever in U.S. 13. es?	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:		14. Race - /	American Indian, White, etc.
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2121	h and Mental Hygiene. 7 is marked other than "n Iraumatic evant, the Medi	Completed	Elementary/Secondary (0-		for 5+)	DO NOT use retired) Owner)	·9	Hair Sal	lon
D ilied	other vant, I	Be C	17. Father's Name (First, Mic	ddle, Last)			18. Mother's Name	(First, Middle, I		LOII
Maryland	Menta	ToB		hington Gard				tiana 1		
Mar Mar	th and 27 is n traun		19a. Informant's Name/Rela Raymond E.	tionship (Type, Print) Gardner/Brot		ing Address (Street a Chrone Hi			-	
	of Health itam 27 i r other tra		20a. Method of Disposition	our unce, me	20b. Place of Disp	osition (Name of	, D		20c. Location - City	
mor Pages	nt: If if		1 □ Burial 2 □ Crema 1 □ Donation 5 □ Other	tion 3 □Removal from St er (Specify)		matory or other place Watters Ce		/05 .	Jarrettsv	ville, MD
Baltimore,	Department important: I any injury o		21. Signature of Funeral Ser M. Gladde	rvice Licensee en Kurtz III,	per DVR	2. Name and Address K.G. Kurt z	s of Facility Jar z & Son Fi			
/1	Medical Medical the prize transit the prize transit the prize transit the prize transit transi	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last	b	r as a consequence of): r as a consequence of): r as a consequence of):	noma of u	inknown pi	rimary		
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ds, P.	signed b	þ	Part II. Other significant cor	nditions contributing to deal Effusion, COP						te to the cause of death?
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Division or Attending	after death. Diractor: A in by the fu	Certification:	3 Suicide 6 □ C	ould not be 28e. Place of	f Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	2	8f. Location (St City or Town		or Rural Route Number,
To tha Hospital	within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	edical Co	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Physician: To the b dical Examiner: On the bas and manne	is of examination and/or in	th occurred at the time	e, date and place, a inion, death occurre	nd due to the ca	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
Toth	withir To th comp	Me	29b. Signature and title of ce	9		29c. License D004	0007		9d. Date signed (M Septembe)	fonth, Day, Year) 27,2005
	8		30. Name and address of pe	rson who completed cause	of death (Item 23a) (Type,	, Print)				
	U		BARBARIT G.	Cook MD	4324 CAMPBE	LL BLVD	WH M	0 0	11236	——————————————————————————————————————
	Sta Registi		OCT 1 3	2005 (1) 32. Reg	of death (Item 23a) (Type, 432.4 (AMBS) gistrar's Signature		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, item251 = State Registrar per M.D., TCHD, 09/20/05, sbb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GILBERT K. FRAMPTON September 182005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Hospital Talbol Memorial 8. Date of Birth (Month, Day, Year) DEC 21 1909 5. Social Security Number 6. Sex / 1 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 219-12-7665 Yrs. Director 95 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other than "natural", or Items 23a or 28e-f show vent, itte Madical Examinational by notified at Yes 2 No **Funeral Director** MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 PORT ST. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER LAWN CARE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be inent of Health and Mental Int: if item 27 is marked o WALTER FRAMPTON LEVINIA NIBLETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA CUMMINGS/STEP-DAUGHTER 8467 TILGHMAN ISLAND RD., WITTMAN, MD 21676 item 27 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: if Ite any injury or ot once. TILGHMAN MEM. CEM. 9/21/2005 TILGHMAN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Straisly Joseph Mr 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Ineumonia **Physician** 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Left physician and s the burial-transit racture resulting in death) Last Due to (or as a consequence of) Physician/Medical Box (23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2X)No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical a liner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 28e. Plice of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☑ No investigation 281. Lottion (Street and Number or Rural Route Number, City or Town, State) 2 Accident 6 Could not be 3 Suicide determined 4 Homicide 208 Port Street, Factor Peryland within 24 hours e To the Funerel 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and of investigation, in the place of the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aidyanatha September 19 2005 Lakshmin L DO57749

State Registrar 31. Date filed (Menth, Day, Year) 2065

30. Name and address of person who completed cause of Jeath (Item 23a) (Type, Print)



Sechot

				Ctata of Manda	nd / Dan	a				
			for Stata	State of Maryla				vientai Hygi	g. No. 200	5 22171
			Registrar		Ce	rtificate of I	Deam	2. Date of Death		
Н	Physicia	an	Decedent's Name (First, Middle, La	•				Month	Day Year	3. Time of Death
	/Medic		Joseph Henry		atrick,				r 27, 200	
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of Deat	ר	4c. County of De	ath
			5809 Nicholson I		and the last selected and the selected	Rockv:	ille If Under 24 Hrs.	I o Date of Birth	Montgo	
r	Funeral			Sex 7. Age (In yrs 11XI M 2□F 83	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 26,	1922 Pe	lirthplace (State or Foreign Country) ennsylvania
	Director		Usual Residence of Decedent	03		1		bane 20,	1322	zimsy i vanita
	/land		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Many -fsh fied	tor	Maryland Montgom	nery R	ockvil]	Le				1 ☐ Yes X ☐ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	h with	O E	5809 Nicholson I	Jane, #106		20852			US	A
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
9	or Ite	F	1 ☐ Never Married 2 ☐xMarried	1 Yes 2 No If Yes, Give WWI			Specify:	o	Specify: Wh	
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		2277				
2	72 h	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done	during most of wor	rking 1	6b. Kind of Busines	ss/Industry
2	within ne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired			11	1-
N	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlems 23a or 28a-f show ther than "healcel Exa of writing the froilified at		17. Father's Name (First, Middle, Last	5+	Print	ing Execu		ne (First, Middle, M	World B	ank
Maryland 21215-0036	od be	Be c	Joseph Henry Fi					izabeth F		on
>	should ind Men marke umatic	2	19a. Informant's Name/Relationship		19b Maili	ing Address (Street)		ral Route Number,		
<u>∞</u>	C1 00 - 00		Mildred M. Fitzp					#106, Ro	•	
စ်	Health Health tem 27 pther tr		20a. Method of Disposition		Place of Dispe	osition (Name of			0c. Location - City of	or Town, State
D L	Pages nent of P ant: If Its		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Cremation 3 ☐		-	matory or other place Heaven Ceme	1000			MICH L. CO. 14
Baltimore,	artme ortan injur		21. Signature of Funeral Service Lice		Maus	Heaven Ceme 19 1e um 2. Name and Addres	ss of Facility	005 S Funeral 1		ing, Maryland
Ba	permit. Departr Imports any infi		Ass. 3	Jalo -						g, MD 20901
			23a. Part1. En er the disease, or con shock, or heart failure. List only	nplications that caused the dea						Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	a. Head and		ancer				Less than
	_				adulance of).					
	Examiner			Due to (or as a conse	equence of):					6 Months
	-33	ier	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conse						6 Months
	-33	ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b						6 Months
o,	-33	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United by the International Control of the	b	equence of):					6 Months
,760,	te be executed ysician and le burial-transit	ical Examiner	that initiated events	b	equence of):					6 Months
89	te be executed ysician and le burial-transit	ical	that initiated events resulting in death) Last	b	equence of):					6 Months
89	te be executed ysician and le burial-transit	ical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b	equence of):	□Ectopic pregnancy			23d. Date of d	lelivery
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State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24, Month **Physician** RALPH LEON GARRISON 2:37PM September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 30478 Pine Knoll Drive Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1⊠M 2□F Yrs. Director 73 December 3, 1931 Maryland 220-28-4933 Usual Residence of Decedent liled within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exercities in an investice redified at 1⊠Yes 2 No Completed by Funeral Director Maryland Somerset Princess Anne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 30478 Pine Knoll Drive 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No 1952— If Yes, Give Year or Dates: 1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Air Force Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ! ပ Jesse Raymond Garrison Arinthia Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is m James R. Garrison (Son) 1520 East Wells Fargo Drive - Olathe, Kansas 66062 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park October 1, 2005 Crisfield, Maryland ^ 4 □ Donation 5 □ Other (Specify) any injury 21. Signature of Funeral Schice Licenses (2019).

Mary Beth Bradshaw-Pruitt Bradshaw & of Son's Funeral Home 306 w. Main Street - Cristield, Maryland 2181/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE LIVER DISEASE **Physician** IYEAR /Medical Due to (or as a consequence of): Examiner ALCOHOLISM 30 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by OBSTRUCTIVE LUN G DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? res 2 No certificate 1 Yes Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 2 No ^oL 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 46962 SEPTEMBER 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. 31575 WINTERPLACE PARKWAY. MD 21804. 31. Date filed (Month, Day, Year) 32. Registar's Signature State Blew & Spark Registrar SEP 2 9 2005

			For	State of Maryland	d / Depa	artmen	t of He	ealth an	id Mei	ntal Hyg	iene			
			State Registrar AMEND#23a(b)per	MD9/28/05.BMW.Mcc	o Cer	tificat	e of D	eath		R	eg. No.	005	33	173
			1. Decedent's Name (First, Middle, Last)						2.	Date of Deat	th	- W - W -	3. Time	of Death
	Physicia		Nathalie P. Garros	-Ferraris					S	Month Septemb	Day	79ar	3:00	a M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or I	Location of D	_	ocp cent		County of Dea)
	Admin	٠.	15316 Pine Orchard	Drive 3B		C.	17.00	Cnair	. ~			Mand		
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under	1 Year	Sprir If Under 24	Hrs. 8.	Date of Birth	14 1	9. Bir	Jonery thplace (State	or Foreign
	Director	Ì	505-48-2853	M x □F 83	Yrs.	Months	Days	Hours I	Min.	(Month, Day,			ountry) France	
	ס	į	Usual Residence of Decedent							/v. 10,		21	Tance	
	ylan how		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Ma-f-s	to	Maryland Montgome	erv s	ilver	Sprin	nα						1 ☐ Ye	s X □No
	r 28	ire	10e. Street and Number			10f. Zip				1	0g. Citiz	zen of What C	ountry?	
	h wit	ai D	15316 Pine Orcha:	rd Drive, 3B			209	06				USA		
	within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-f show the Modical Examiner must be modified at	Funerai Director	11. Marital Status	Was Decedent Ever in U.S Armed Forces?		Was Deced	dent of His	panic Origin	? (Specify	y Yes or No-	1	4. Race - Am		
ပ	after or its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 K No		_		, Mexican, P	ruento Hic	an, etc.)		Black, Whi		
Ö	al', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 X J No	Specify:				Specify: Wh	nite	
215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usua	al Occupat	tion uring most of	f working		16b. Kir	nd of Business	/Industry	
2	thin 6.	ple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us			working					
7	filed within I Hygiene. other than ant, the M	Son		4	Те	acher	<u> </u>				F	rench		
b	e file al Hy oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's	Name (F	irst, Middle, I	Maiden .	Sumame)		
Maryland	uld b Ventz rrkad rice	Tof	Henri Garros					Rosal	lie G	iudici				
ar	sho s s ma		19a. Informant's Name/Relationship (Type			-						Town, State,		
	alth alth		Karen N. Valby/	Granddaughter	321	13th	Stre	et, Br	cookl	yn, Ne	w Yo	ork 112	215	
re	s 1 s of He itam oth		20a. Method of Disposition	1 0	ace of Dispos	sition (Nar	ne of	S	ept.	23,	20c. Lo	cation - City or	Town, State	
E	Page ent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	amovai from State	ropolita				2005		leva	andria,	Virai	nia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injugy or other traumatic event, the Medical Examiner must be multified at once.	- 1	21. Signature Fun, ral Service License							neral			virgi	mia
ã	per Dep any		- Caroline	A Colo	50	ancıs O Uni	vers	itv Bl	ıs ru vd.	neral W. Sil	Home	e Inc Spring	MD 2	0901
	- A		23a. Part1. Enter the disease, or complic	cations that caused the death								phrine	Approxima	
			shock, or heart failure. List only on Immediate Cause (Final	e dause on each line.			, , ,	,		, , , , , , , , , , , , , , , , , , , ,			Interval Be Onset and	atween
	Pnysician /Medical	ř II		Right-Sided I		Failu	ıre						2 yea	rs
П	Examiner			Due to (or as a consequ		i							5	
		_		Porto-pulmonary Due to (or as a consequ		15.01							2 years	S
Т	ed isit	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury	200 10 (0) 23 2 0013040	101100 01).									
	and I-trar	хап	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):									
68760,	icate be executed physician and s the burial-transit	E		223 12 (3. 23 2 33.1334)										
87	cate ohysi the l	dicai	d											
		0	IF FEMALE:	20. 16.000.000.000.06.0000.06										
Вох	death certif e attending od for use as	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3	Ectopic pr					2	3d. Date of de Month	livery Day	Year
0	0 0 0	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (sp	pecify)						,	
<u>Ч</u>	that the death	Physician/M		Asibustica to death but and and	Min - I - M	- 4 - 1 3		D. At		On Didan				
Ś	90 00	by	Part II. Other significant conditions con Cerebrovascular Ac		litting in the ur	naeriying c	ause giver	n in Paπ I.				se contribute t		
Record	w require been si should b	Completed		70146116					-	1 L Y €	es 2.8	No 3□P	robably 4 L	JUNKNOWN
ecc	law r as be 2 sh	ple								24a. Was a autops		24b. Were a	utopsy finding completion of	s available cause of
ď	The law cate has page 2.9	от								perform	ned?	death? 1 ☐ Yes	_	
Vital	Physician: Th rthis certificate ral director, pag	O	25. Was case referred to medical					26. Place of	f Death (C	heck only on				
>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 X No	ospital: 1 Inpatient 2 I	ER/Outpatien	nt 3 🗆 DC	Other	r: 4 🗌 Nursi	ng Home	5 😿 Reside	ence 6	☐Other (Spe	cify)	
1 of	g Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 2	28c. Injury Work			l. Describe ho				
<u>ō</u>	Attanding For death. actor: After by the funer	atio	1 XNatural 5 ☐ Pending investigation	(manary Day 7 dar)	mjary	М		es 2□No						
Division	Atta acto by th	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, tarm, str	eet, factory	y, office		28f.			Number or R	ural Route Nu	mber,
ā	i Sir G	Certification:		building, etc. (Specify	,					City or Towr	., Jiaie)			
	To the Hospital or Attanowithin 24 hours after death To tha Funaral Diractor: completely filled in by the		29a. Certifier 1⊠ Certifying Phys	icien: To the best of my know	wledge, death	n occurred	at the time	e, date and p	olace, and	due to the ca	ause(s)	and manner a	s stated.	
	ne Hc	edical	(Check only 2 Medical Exemir one)	ner: On the basis of examinat and manner stated.	ion and/or inv	vestigation	, in my opi	inion, death	occurred	at the time, d	ate and	place, and du	to the cause	(s)
	To the within To the somp	Me	29b. Signature and title of certifier	,		290	c. License	number		2	9d. Date	signed (Mon	th, Day, Year)	
	4.5		I bleeva f. Sh	ариго но			D35	5336		;	Sept	ember	23, 200	05
	10		30. Name and address of person who co		23a) (Type	Print)								
			Deena Shapiro, M.				venue	e. Ken	sina	ton. Mi	D 20	895		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa		,	-	,	9	,				
	Regist		CED 9 0 200	75 1	10 1	a. N. 8	1							

			For State Registrar	State of Man	-	artment of H			000) E	20175
			Decedent's Name (First, Middle, Last)					2. Date of De.		12-	3. Time of Death
	Physicia /Medic		Anthony John Gan	ngemi				Septe	mber 24	4,200	05 7:30 [™]
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or		th	4c. County		
			7845 King Arthur 5. Social Security Number 6. Sex		n um lant hirthdoul	White I		9 Date of Rid		rles	(2)
	Funeral Director			M 2□F 55	n yrs. last birthday) Yrs.	Months Days	Hours Min	8. Date of Bird (Month, Da April	7, Year)	Oounti Massa	ace (State or Foreign ry) achusetts
			Usual Residence of Decedent						,.,,,,,,,,		
	arylar show	Ž	10a. State 10b. County	11	Oc. City, Town or Lo					10	0d. Inside City Limits 1 Yes 2 No
	28a-f	ecto	Maryland Charles 10e. Street and Number		White P	10f. Zip Code			10g. Citizen of V	What Count	
	as or	Funeral Director	7845 King Arthur Ct			20695			U.S.A.	viiat Oouiiti	. y :
	death	nera		2. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No		e - America	
ထ္ထ	after or ite	/Fui	1 ☐ Never Married 2 【X Married	Armed Forces? 1 ☐ Yes 27 No If Yes, Give		ryes, specny Cuba 1 □ Yes 2 □XNo		no Hican, etc.)	Specify	ck, White, e	
8	hours tural',	Completed by	3 Widowed 4 Divorced	Year or Dates:						AAT T.T.	
Ϋ́	in 72 n "nat	plete	15. Decedent's Educi (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turing most of wo	orking	16b. Kind of Bu	isiness/indi	ustry
212	d with giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Pro	gram Anna	lyst		U.S. Go	vernm	ent
2	tat Hy d othe	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Suman	10)	
<u>Y</u> a	Menidal Menida Menida Menida Menida Menida Menida Menida Menida Menida Menida Menida Menida Me	4	Dominic J. Gangemi					a Bitale			
Maryland 21215-0036	d 2 sh th and 17 fs n traun	r V	19a. Informant's Name/Relationship (Typ Cynthia L. Travis	Wife		ng Address <i>(Street a</i> 5 King Ar					
<u>ق</u>	tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	ما حال	Date	20c. Location -		
E	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metropol:	itan Fune	"Sept.2" ral Ser	7,2005 vice	Alexand	ria,	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumetic event, If a Medical Exerticer must be notified at once.		21. Signature of Funeral Service License		0.660 ₩.	illiams F 270 Hawth	uneral 1	Home, P.A	A.	MA 2	10640
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the							Approximate Interval Between
J.	Physician		Immediate Cause (Final disease or condition	Lause on each line.	NG	CA	NCE	$=\Omega$			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						
	Cxammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	oncoguence of):						
	nsit	Examiner	Cause (Disease or injury	Due 10 (01 as a c	onsequence or,						
Ć,	execu in and rial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):						
8760,	icate be executed physician and s the burial-transit		L d.								
9	ertifica ling ph e as tl	Physician/Medical	IF FEMALE:								
Вох	death certific e attending p id for use as i	ian/	in the past 12 months?	lc. If yes, outcome of 1☐Live birth 2 [4☐Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				te of deliver nth	y Day Year
o.	0 0	ysic	1 Yes 2 No 9 Unknown	9 Unknown	ie or death 5 L						
S,	The law requires that the ate by the bas been signed by the bage 2 should be detache	by Pr	Part II. Other significant conditions cont	ributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?
ğ	w require been sig should b	ed t						101	res 2□No	8 Proba	ably 4 □Unknown
Vital Record	e law re has be je 2 sh	Completed						24a. Was)Sy	prior to com	sy findings available
<u>ح</u>		Con	_					perfo		death? I□Yes 2	2□ No
Zi Zi	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	20	ath (Check only o			
of	Attending Physician: r death. sctor: After this certifice by the funeral director.	7: To	1 ☐ Yes 2 ☐ Yo 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	f 28c. Injury	at Nuising	Home 128d. Describe	dence 6 ∐Oth- now injury occurr)
<u>o</u>	utending I death. ctor: After the funer	ation	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Y	ea <i>r)</i> Injury	Work M 1□	<7 Yes 2 □ No				
Division	of or Attence after death Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physi (Check only one)	ician: To the best of ref. On the basis of exand manner state	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Λ . Λ .	DA	29c. License	number		29d. Date signed	J (Month, D	Day, Year)
)			House	Ma	elle	00	2831	2	9/2	6/0	5
0	\$5		30. Name and address of person who cor	npleted cause of deat	th (Item 23a) (Type,	Print)	Plat	G 1	S	20	646
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2	32. Registrar's	Signature	Sperte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29 Physician 2005 0507 M Clarence L. Ganzman, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ELKTON HOSPITAL UNION If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 16,1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**-X**M 2□ F Yrs. Director 216-16-5128 79 MD Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location should be filed within 72 hours after deeth with the Marylan nd Mental Hygjene.
I marked other than "naturel", or Items 23a or 28a-f show matic event, the Mcdical Examiner must be notified at 10d. Inside City Limits 1 ¥ Yes 2 □ No Directo Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 W. High Street 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3√2 Widowed 4 □ Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Shipping Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Conrad Ganzman Cenia Spratt and A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) continent of Health a cortent: If Item 27 Is injury or other tree 21911 Ronald Ganzman/son 2142 Theodore Rd, RisingSun, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.A. Ferris, Inc. Sept. 30, West Chester, PA 22. Name and Address of Facility 005 21. Sin atur of there ervice Licensee Andrew G. Gee Funeral Home 23a. Part1. Erfter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiamyopa **Physician** Year /Medical Due to (or as a consequence of): Examiner YPE labetes rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Vascular ear eripheral Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 🗆 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 ☑Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one)

10+IVA

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SEP 3 n 2005

30. Name and address of person who comp



leted cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

ELKTON, MARYLAND

September 29,2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 _ State	epartment of Health and Mental Hyg Certificate of Death	iene
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	^{9. No} 2005 331.7.7
	Physici	an	Helen Mary Gulick	Month	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1	Examin	er	Citizens Nursing Home	Havre De Grace	Hanford.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
н	Director		175-20-1660 1□M 21XF 85 Yr	Months Dave Hours Min /Month Dav	Year) 2.1920 PA
	ը .		Usual Residence of Decedent		,
	arylar show	_	10a. State 10b. County 10c. City, Town (or Location	10d. Inside City Limits
	8a-f	Director	MD Cecil Rising		1 X Yes 2 □ No
	with the		10e. Street and Number		0g. Citizen of What Country?
	s 23s	rai	408 Dodson Drive	21911	USA
	er de Item Der p	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	14. Race - American Indian, Black, White, etc.
36	I', or	by	1 Never Married 2 Married 1 Yes 2 M2 No If Yes, Give 3 M2 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 💢 No Specify:	Specify: White
ŏ	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, Ite Medical Eraminar must be notified at	ted	15. Decedent's Education 16a, D	ecedent's Usual Dccupation	16b. Kind of Business/Industry
212	7 old " un " un	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working ife. DO NOT use retired)	,
21	be filed within 72 ho tal Hygiene. d other than "natul event, ire Medical	Completed		. Owner	Resturant Business
B	e filed al Hygi t other vent, I	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)
<u>la</u>		7	John Jubas	Antonia Lubert	
Baltimore, Maryland 21215-0036				Mailing Address (Street and Number or Rural Route Number,	
2	s 1 and 2 f Health item 27 l		Russel J. Gulick/son 8	94 New Bridge Road, Rising	
O.	S - = D		I Libraria: 2 Licientation 3 Chemioval nom State	crematory or other place) 09-30-2005	20c. Location - City or Town, State
ţ	t. Pa tmen tant: njury				Northern Cambria, PA
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility R.T. Foard 111 S. Queen Street, Rising	Funeral Home, P.A. Sun, MD 21911
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		
	Pnysician		Immediate Cause (Final disease or condition	CANEMA	Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence of	: :	
	Examiner		Sequentially list conditions b.		
	De iii	inei	Sequentially list conditions, if any, leading to immediate raises. Free Indefining Cause (Disease or injury	i:	
	and I-trans	Examiner	cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of	v	
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	E E	Due to (u) as a consequence of		
87	physic the	dicai	d		
9 X	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery
Вох	atter I for u	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
0	that the de ed by the detached	Physician/Me	1 Yes 2 No 9 Unknown		
a .	s that ned b e deta	by PI	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?
rds	quires an sign uld be	d be	Columpay Apiquy pisepise	1 ☐ Ye	s 2 No 3 Probably 4 Unknown
S	law requas been 2 shoul	Completed	CMIGESTIVE MEMIT FAILURE	24a. Was ar	
Ä	The laste has page	E		autops perform 1 Yes 2	prior to completion of cause of death? No 1 Yes 2 No
Vital Records,		BeC	25. Was case referred to medical	26. Plage of Death (Check only one	
of V	S S	5	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3☐ DOA Other: 4 ✓ Nursing Home 5 ☐ Reside	nce 6 Other (Specify)
n c	ng fte	ino :	27. Many r of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury		w injury occurred
sio	Attandideath. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No	
Division	or At fter d Sirect in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location (Str. City or Town	eet and Number or Rural Route Number, , State)
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 V Certifying Thysician: To the best of my knowledge.	Lab variable by the same	
	8 Hos 24 ho Fun etely	Medical	(Check only one)	Jeath occurred at the time, date and place, and due to the ca or investigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. ite and place, and due to the cause(s)
	To the Hospital within 24 hours of To the Funeral completely filled	Me	29b. Signature and title of certifier	29c. License number 29	od. Date signed (Month, Day, Year)
	->-0		> Hisupla	D46412	9/16/05
	6		ame and address if person who completed cause of death (Item 23a) (T	ype, Print)	1-1.
7=	9		Mi sup sin 319. 5, 1411101	AUR HAL MY 21078	1
B	Sta		31 Date filed Month, Day Year). 2005 62. Registrar's Signature	parte	

		1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 33178										
	Physici		Decedent's Name (First, Middle, Last) NORMAN E. GRIFFIN		2. Date of Death Month	Day Year 7 2005 01:11 M						
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town Peninsula Kegional Medical CTR.	n, or Location of Death Salish	way	4c. County of Death Wicomico						
	Funeral Director		5. Social Security Number 220-28-4881 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 73 Yrs. If Under 1 Ye Months Da	vs Hours Min.	8. Dáte of Birth (Month, Day, Yei)6-25193	9. Birthplace (State or Foreign Country) 2 MARYLAND						
	Maryland a-f ehow	tor	10a. State			10d. Inside City Limits 1 ☐ Yes 2√☐ No						
	with the	Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
d 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Items 23a or 28a-1 ehow appriatury or other treumatic event, the Madical Examinat must be notified at an once.	Funeral Director	3871 MEADOW BRIDGE ROAD 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married	Black, White, etc.								
	72 hours a natural', o	by	3√ Widowed 4 □ Divorced Year or Dates 1955 – 57 15. Decedent's Education 16a. Decedent's Usual Oc		16b.	Specify: WHITE Kind of Business/Industry						
	ed within ygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use re ROUTE SUPER	visor	В	EVERAGE SERVICE						
Maryland	12 should be fill and Mental H. Ie marked other reumatic even	To Be	18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)									
	nd 2 st alth and 27 ie n r treun		I was a second of the second o			y or Town, State, Zip Code) MARYLAND 21658						
Baltimore,	Pages 1 enemon of Heamint: if Itam		20a. Method of Disposition 1 \(\overline{\text{Meurial}} \) 2 \(\overline{\text{Cremation}} \) 3 \(\overline{\text{Removal from State}} \) 8 Place of Disposition (Name of cemetery, crematory or other) 4 \(\overline{\text{Donation}} \) 5 \(\overline{\text{Other}} \) (Specify) SPRINGHILL MEM.	f Da	te 20c.	Location - City or Town, State BRON, MARYLAND						
Balt	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804									
	Physician		23a. Part 1 Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer									
-	/Medical Examiner		Due to (or as a consequence of):									
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):									
8760,	cate be executed physicien and the burial-transit	Ical	Due to (or as a consequence of): d.	, d.								
P.O. Box 6	Attending Physicien: The law requires thet the death certificate be executed rideath. rideath. ector: Atter this certificate hes been signed by the ettending physicien and y the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specify 9 Unknown 5 Other (specify 9 Unkno			23d. Date of delivery Month Day Year						
	w requires thet been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		o use contribute to the cause of death? 2 Mo 3 M Probably 4 Munknown						
Division of Vital Records,	The law requisate hes been page 2 should	Completed			24a. Was an autopsy performed							
Vita	ysicien: The l is certificate he director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (
ion of	nding Phys th. : After this s funeral di	- 1	27. Manner of Death 1	4 🗆 Nuising Home	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
_	To the Hospitei or within 24 hours afte To the Funarei Dir. completely filled in It.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	With Com	2	I lu Sul	ense number	29d. Date signed (Month, Day, Year)							
,	1,00		30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) (NIIS Snyder, M.P. 100 E Carroll St Salisbury MD 21804									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (NIS Sing der, M. D. 100 E Carroll St. Salisbury M.D. 21804 State Registrar SEP 2 8 2005 September 15 September											

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ruth Grav September 26 2005 22:55 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1926 Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F YIS 579-30-1945 78 December Director South Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show The Madical Exprimer must be notified at Yes 2 No Directo Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12619 Kavanaugh Lane U.S.A. 20715 permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, Ire Marited Exprision Irust Instal any injury or other traumatic event, Ire Marited Exprision Irust Instal engines. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nurses Aide Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) General Bright Julia Mance 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Veronica Winston/Cousin 1325 Oates St. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD National Cemetery 10-05-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB Jenkins Funeral Home 7474 Landover Rd LAndover, MD 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Renal Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Chronic Respiratory Failure that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 XNo 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MacUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform rmed? 2 ♣No certificate 2 \ No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 05 D16273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy, MD 6130 Landover Rd Cheverly, MD 20785 32. Registrar's Signature Date filed (Month, Day, Year) State SEP 3 0 2005 Registrar

			1 - For State Registrar	State of M	aryland		artment <i>tificate</i>			ınd M	lental Hy	ygiene Reg. No.	A 400	05	33180	
	Physici		Decedent's Name (First, Middle, Last) Wolfgang				Gottheit				Date of Death Month Day Ye			Year 005	3. Time of Death 5:18 A M	
1	/Medio	4	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					4c. County of Death				
			Frederick Memor					eder					Fred	eric		
	- Funeral Director		5. Social Security Number 6. 138–32–6066	. Sex 7. Ag 1 ★ 2 ☐ F	je (In yrs. I. 68	ast birthday) Yrs.	If Under 1 Months	Days	Hours 1	Min.	8. Date of B	lay, Year)	27	~	ace (State or Foreign ry)	
	100 p		Usual Residence of Decedent		00						May 28	5, 19.	3/	Gern	nany	
	Marylank f show	jo.	Maryland Fred	erick		r, Town or Lo Freder:								10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	r 28a-	Director	10e. Street and Number				10f. Zip Code					10g. Citi	0g. Citizen of What Country?			
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or tems 23a or 28a-f show event, the Medical Examinar must be notified at	al D	5613 Glen Cove Court				21703					Unit	United States			
036		by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	•		Vas Decede f Yes, specif I □ Yes 2			gin? (Spe , Puerto	ecfy Yes or N Rican, etc.)		14. Race Black	- America , White, e Whi	an Indian, etc.	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1)		5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer				ng	16b. Kind of Business/Industry Manufacturing					
d 2	I Hygi other	BeC	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middl				116	
/lar	s 1 and 2 should be f Health and Menial item 27 is marked o other traumatic eve	ToB	Ferdinand	Gotth	eit					Loui	se	Ap	ple			
Maryland		0.0	19a. Informant's Name/Relationship	(Type, Print)			-				/ Route Num.	_		-		
	1 and Health em 27		Vicki Gottheit 20a. Method of Disposition	/ wife	205 PI	5613 lace of Dispo			re Ct		rederi			and City or Tov		
Baltimore,	permit. Pages 1 Department of H important: if ite any injury or ot once.		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Cé	emetery, crer thaver	natory or oth Mem. (er place Gard	en 10	0/03	/2005	Fred	eric	k,Ma:	ryland	
Balt			21. Signature of Funeral Service Lice	Beler	a son						uffer ke, Fr				, P.A. 1702	
	Physician physician and physic	23a. Part I. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Authority the disease or condition and the cause of the death of the cause of the cause (Final disease or condition and the cause of the cause (Final disease) are caused the death of the cause of the										Approximate Interval Between Onset and Death				
, °C		-6		b. Due to (ordas	a conseque	ille	ale	It	76	a	ily	<		-	Sh	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the co				it):									
8760,	ate be hysicia ihe bu	dicai		d												
.O. Box 68	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pred						23d. Date Mon	of deliver	y Day Year	
0		ρ	Part II. Other significant conditions	ulting in the ur							obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Onknown					
Vital Records,		Completed										s an opsy formed? 2 No	pr de	or to com	sy findings available apletion of cause of	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was casa referred to medical examiner?	Hospital:				1 -			(Check only					
þ	S S	٦.	1 Yes 2 No	1 ☐ Inpati		ER/Outpatien 28b. Time of			4 🗆 1901		ne 5 Res)	
	nding th: After a funer	tion	1- Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)	Injury	м	injury : Work? 1 □ Y	es 2		-		, 55525			
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)								Route Number,					
		edicai C									ited. the cause(s)					
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	au		30. Name and address of person when the state of the stat	o completed cause of	~~	S.	Print)	1	edl	Ros	enberg	S	-	U	132	
DH	Sta Registi	rar		9 2005	Sys		Grante.	· /				_		-22		

			For State Registrar	Sta	te of M	arylan	d / Depa <i>Cei</i>	artment tificate			and Mei		giene Reg. No.	005	331	81
H	Physici	an	Decedent's Name (First, Midd	le, Last)		-	1					Date of De Month	Day	Year	3. Time	
	/Medic		The 1ma 4a. Facility Name (If not institution	n dive street a	nd number		rdon	4b. City, T	own or l	ocation o		epteml		2005 County of Death		:30P ^M
	Examir	er	Casey House	,, g,,, o,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					kvil		, , , , , , , , , , , , , , , , , , , ,			ntgome		
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. I	last birthday)	If Under 1		If Under	24 Hrs. 8. Min.	Date of Birt (Month, Da	h		nplace (State untry) Un	or Foreign
	Director		587-18-6894	1 □ M 2	MF	58	Yrs.	MOTITIS	Days	Tiodis		ct. 2	1, 19	146	unuy) UII:	
	and 1		Usual Residence of Decedent 10a. State Unk 10b. County	'Unk		10c. City	y, Town or Lo	cation]]n]	<u> </u>						10d. Inside (City Limits
	Mary f sho	ţ						OIII							1 🗆 Ye	Unk 2□No
	a or 28e	i Director	10e. Street and Number Unk			.1		10f. Zip (Code [Jnk			10g. Citiz	en of What Co	untry? Unl	ζ
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show gifted Evarating must be collited at	by Funerai	11. Marital Status Unk 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced	ried 1 [s Decedent ned Forces? Yes 2 es, Give ar or Dates:	' Unl	.c 1	Vas Decede f Yes, speci	fy Cuban	panic Ori , Mexican Specify:	gin? (Specify , Puerto Ric	y Yes or No an, etc.)		4. Race - Amer Black, White Specify: B1a	etc.	
9	2 hou	ted	15. Deceder	nt's Education			16a. Deced	lent's Usual	Occupat	ion Un	k, ,			d of Business/I		nk
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and 2	be file tal Hyg d othe	Be	17. Father's Name (First, Middle,							18. Mothe	r's Name (F	irst, Middle,	Maiden S	Sumame) Ur	ık	
Maryland 21215-0036	d 2 sh h and 7 Is m traum	^L	19a. Informant's Name/Relation:	ship <i>(Type, Prii</i>	u) Unk		19b. Mailir	g Address	(Street ar	nd Numbe	er or Rural R	oute Numbe	ar, City or	Town, State, Z.	ip Code) [Jnk
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		I from State		_I lace of Dispo emetery, cren	sition (Nam- natory or oth	e of UT her place	k	Date	Unk		ation · City or I		
Balti	permit. Page Department Important: If any Injury or once.		21. Sign ture Funeral Service		Tare		22 V	Name and Vest F	Address uner L.K.	of Facilit al H St.	ome Natcl	nez. M	ıs 39	120		
			23a. Part1. Enter the disease, or shock, or heart failure. Lis	r complications	that cause	d the death									Approxima Interval Be	ite stween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aW:		Metas	static uence of):	Cervi	ical	Carc	inoma				Onset and	
L	Examiner	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause Disease or injury	b	ue to (or as	a consequ	ueiTce of).				-					
oʻ.	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or as	a consequ	uence of):									
8760,	cate be ohysicia the bu	dical		d												
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1	es, outcome Live birth Pregnant a Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23	3d. Date of deliving Month	very Day	Year
0	quires that n signed by ald be deta	by	Part II. Other significant conditi	ons contributin	g to death t	out not resu	ulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to	_	e contribute to	the cause of	
Records,	The law requir ate has been s page 2 should	Completed								_		24a. Was autop perfor		24b. Were aut prior to co death? 1 ☐ Yes	ompletion of	available cause of
Vital	clan: artifica octor,	Be	25. Was case referred to medica examiner?								of Death (C					
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 📉 No	Hospital	1 Inpati		ER/Outpatien			4 LI NU				Other (Special	ity) Hos	pice
		ion	27. Manner of Death 1 X Natural 5 ☐ Pendi		Date of Inju (Month, Da	lry ly Year)	28b. Time of Injury	28 M	ic. Injury : Work?	at es 2 □ !		. Describe h	iow injury	occurred		
Division	r Attenter ter deat irector:	Certification;	3 Suicide 6 □ Could	not be nined 28e.	Place of In building, e	jury - At ho tc. <i>(Specif</i> y	ome, farm, stro			as 5 🗀 i		Location (S City or Tow	Street and m, State)	Number or Rui	ral Route Nur	nber,
	To the Hospital c within 24 hours af To the Funeral D completely filled in	edicai Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: Examiner: Or	To the best the basis of d manner st	of examinat	wledge, death tion and/or inv	occurred a	t the time	, date and nion, deat	d place, and th occurred a	due to the dat the time, d	cause(s) a date and p	nd manner as : place, and due !	stated. to the cause(s)
	within To the comple	Me	29b. Signature and title of certific		1			29c.	License	number			29d. Date	signed (Month,	, Day, Year)	
)	0		XTILLE	11	C)4	1)	12		9	16/0)5	
			30. Name and address of person	who complete	d cause of			,	-80 3158		7 0		-11		9	
			Charles Har	1	M.D.		001 Mur	caste	r Mi	.11 R	d., Ro	ckvil	1e, 1	MD		
	Sta Regist		OCT 1	3 2005		_	K A	aut i								

DHMH 17 Rev 1/2001

ORIGINAL

Daniel Gloden 05-6554 AGK

0004		. For	State of	of Marylar	nd / Depa	artment o	of Healt	th and N	Mental Hy	giene		
	_1	= State Registrar			Cei	rtificate	of Dea	ith		Reg. No.2	15	33182
Physicia		1. Decedent's Name (First, Middle,	ast)						2. Date of De Month	ath Day	Year	3. Time of Death
/Medica		Daniel Harold	Gloden						Septem		2005	7:08 A M
Examine	r	4a. Facility Name (If not institution, g				· ·		tion of Death		4c. County		
		Southern Marylar 5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday	Clin		nder 24 Hrs.	8. Date of Bir			orge's
Funeral Director		594-03-7264	1 X M 2□F	33	Yrs.	Months E	ays Hou	urs Min.	June 23	v. Year)	Cour	land
2	-	Usual Residence of Decedent				1			<u> </u>	,		
arylar ehow		10a. State 10b. County		10c. C	ity, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 🗶 No
Ne M	Director	Maryland Charl 10e. Street and Number	es		Wald					10- 011		
with the sor	2	No. of the last of				10f. Zip Co		0.1		10g. Citizen of W		ntry?
na 23	runeral	1610 Debra Drive		edent Ever in U	J.S. 13. 1	Was Deceden	206		ecify Yes or No	- 14. Race		an Indian.
ther of the real		1 Never Married 2 Married	Armed F	2 X No	i				ecify Yes or No Rican, etc.)	Black	c, White,	etc.
030 Surs a	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1⊡Yes 2⊠	No Spe	ecify:		Specify:	W	hite
1215-0036 within 72 hours after death with the Maryland one then "neturel", or Itema 23a or 28a-1 show the Madical Examinar must be notified at	Completed by	15. Decedent's (Specify only highest)	16a. Dece	dent's Usual (kind of work of DO NOT use	occupation one during	most of work	king	16b. Kind of Bu	siness/In	dustry
Men.	<u>a</u>	Elementary/Secondary (0-12)	College ((1-4or 5+)			etired)			11-4	- 7	
ind 2: be filed v ital Hygie d other t		17. Father's Name (First, Middle, La	st)		Mar	nager	18 M	Aother's Nam	a (First Middle	Hot Maiden Sumame		
d be antal	0 00	Edward Junior G1	,						Marie		-,	
S DE E		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (S	treet and No			er, City or Town,	State, Zip	Code)
Te, March 1 and 2 Health a Hea		Joyce Almond - M	lother		6135	Goode	Road,	Hughe	sville,	MD 2073	6	
of He of He roth		20a. Method of Disposition 11 Burial 2 ☐ Cremation 3	□ Bamayal from	1	Place of Dispo cemetery, crei	sition (Name matory or othe	of or place)	1	Date	20c. Location -	City or To	wn, State
altimore, mit. Pages 1 ar partment of Hea portent: If Item y injury or othe	1	4 Donation 5 Other (Spe		Tr	inity M	1emoria	1 Gdn	s 9-30	-2005	Waldor	f, M	D
Baltimor permit. Pages Department of h Importent: if Its eny injury or of once.		21. Signature of Funeral Service Lie	censee	M0139	1 22	2. Name and	Address of F	acility		. Box 15		
205.9	7	grayan				<u>luntt F</u>				orf, MD	2060	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on	each line.	itn. Do not eni	^			1			Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. All	work	entu	(av	diov	ascu	las L	isaul		
Examiner			Due to	(or as a conse	quence or):							
	<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to	(or as a conse	quence of):							
cuted	Examiner	that initiated events	c									
SO, e exe sien a urial-i	ŭ	resulting in death) Last	Due to	(or as a conse	quence of):							
Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	dicai		d									
Box 68 death certifica attending ph	Physician/Me	IF FEMALE:	23c If yes or	utcome of pregr	nancy					and But	-6-4-15	
Box eath cer attendin for use	Clan	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 ☐ Fet nant at time of	al death 3	Ectopic preg				23d. Date Mon		ory Day Year
P.O. B that the death ed by the atterded for	Š	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr									
	2	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	inderlying cau	se given in F	Part I.	23e. Did t	obacco use contr	bute to th	ne cause of death?
cord:									10	Yes 2 ² □No	3 Prob	ably 4 □Unknown
Recc The law re te has be	be								24a. Was	an 24b. V	ere auto	psy findings available mpletion of cause of
Vital Records, strien: The law requires to certificate has been signs recor, page 2 should be	Completed								1 X Yes	ormed? d	eath?	2□ No
of Vital F Physicien: Th this certificate ral director, pag	e n	25. Was case referred to medical examiner?	Hospital:				7	Place of Dea	th (Check only o	one)		
Physical Parts	<u> </u>	tion Yes 2 No 27. Manner of Death	28a. Date		28b. Time o			Nursing H		dence 6 Othe		y)
dlng dlng h. After funer		1 Natural 5 Pending 2 Accident investiga	(Moi	nth, Day Year)	Injury	м 200	lnjury at Work? 1 ☐ Yes	2 □ No	280. Describe	now inputy occurre	, C	
Division for Attending efter death. Director: After	Eca	3 Suicide 6 Could no	t be 28e. Plac	e of Injury - At I	home, farm, st				28f. Location (Street and Number	or or Rura	I Route Number,
Div	Certification:	4 Homicide	build	ding, etc. (Spec	ufy)				City or To	wn, State)		
Di To the Hospital or Within 24 hours eft To the Funerel Dir completely filled in	Cai	29a. Certifier 1 Certifying (Check only 2-Medical E	Physician: To the	e best of my kr	owledge, deat	h occurred at	the time, da	te and place	and due to the	cause(s) and mai date and place, a	ner as si	tated.
To the H within 24 To the F complete	Medical	one)	and mai	nner stated.	ation and of in				neo at the time,			
To To Com	Σ	29b. Signature and title of certifier	11-1	MA			icense num OCME	IDer		29d. Date signed		,
(-	JAN 1	X	V V \						Septembe	er Zi	, 2005
RIX		30. Name and address of person w	no completed dat	use of death (Ite			n Stre	eet Ba	altimore	e, Maryla	and 2	21201
Stat	e_	31. Date filed (Month, Day, Year)		Registrar's Sign	nature							
Registra		SEP 2 9	2005	lous	K 4	backs						

05-6727 B.K.S JOHN R. GOUGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Depa

artment of Health and Mental	Hygiene	n	\cap	5	2	2	1	Ω
rtificate of Death	Reg. No.	U	U	J	J	J	1	U

	•	For State Registrar	State of Maryland	Cei	rtificate of	Death	nemai my	Reg. No		33183
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day		3. Time of Death
/Medic Examin		John Robert Gough 4a. Facility Name (If not institution, give st	reet and number)			or Location of Death	OCT,	4c.	. County of Death	
		41035 MEDLEYS NECI 5. Social Security Number 6. Sex	X ROAD 7. Age (In yrs. la	et hirthday)	LEONAR		9 Date of Bi		ST.MARY'	
Funeral Director			M 2□ F 36	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Date of Bi July 2	ay, Year)	969 Mary	place (State or Foreign intry) y land
and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ecation					10d. Inside City Limits
Mary	ţŏ	Maryland St. Mary's	s Leon	nardto	wn					1X Yes 2 □ No
with the	Funeral Director	10e. Street and Number	D 1		10f. Zip Code				tizen of What Cou	,
death ms 23	erai	41035 Medleys Nec	2. Was Decedent Ever in U.S	i. 13.	20650 Was Decedent of F	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N		14. Race - Amer	ican Indian,
DESIGNATION CONTROLLY INCLUDED DESIGNATION OF THE PROPERTY PROPERT	ğ	1 → Never Married 2 → Married 3 → Widowed 4 → Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 💢 No		Rican, etc.)		Black, White Specify: Wh:	
n 72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ring	16b. K	(ind of Business/li	ndustry
d withing giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler				Gr	rocery	
id be file ental Hy ked oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			,	
should and Mer market	ို	John H.B. Gough 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailie	ng Address (Street	Mae V.				p Code)
and 2 st and 2 st saith and n 27 ie r		John H. B. Gough		P.O.	Box 358	Leonardto	wn, Mai			
or oth		20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Re	milovai iloili State		sition (Name of matory or other pla	1	Date		ocation - City or T	
DESILUTION Description of Descriptio		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			S Cemeter 2. Name and Addre			_	onardtow ineral H	n, Maryland
g gg g g		Kyle S. Simons	M01206			DI				land 20650
Pnysicia i /Medical Examiner	_	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one trimediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of the death.	OG ence of):	er the mode of dy	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
ate be hysick the bu	Aedicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent							
death celle attendiged for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[□Ectopic pregnanc □ Other (specify) _	:y			23d. Date of delin Month	very Day Year
ords, F.C. requires that the een signed by th nould be detache	Ď	Part II. Other significant conditions conf	nbuting to death but not resul	lting in the u	nderlying cause gr	ven in Part I.		tobacco		the cause of death?
The lar	Completed								prior to co	opsy findings available ompletion of cause of 2 No
OT VICAL Physicien: this certifica	Be	25. Was case referred to medical examiner?	ospital:		04	26. Place of Deal			V	
OT Phy or this	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	ome 5 Res 28d. Describe			AT SCENE
Z = . Z =	catio	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 Suicide 6 □ Could not be	10-3-05	3:30	AM 1	ork?]Yes 2. No		ud	hauge o	,
in Diffe	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, st	reet, factory, office MOME		NUF KI	PLOT	alatown,	ral Route Number, MEDLEYS St. Marrys Co. M.D.
H T P	edicai	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Exemin	ician: To the best of my know er: On the basis of examinati and manner stated.	Wedge, deat ion and/or in	h occurred at the ti vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s , date and) and manner as d place, and due	stated. to the cause(s)
To the within 2 To the complei	Me	29b. Signature and afficient certifier	M		29c. Licen	se number ME			te signed (Month)	
			-V							

State Registrar

6 2005 Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT. 17, ^{Day} 2005 **Physician** 1230AM **GLADYS** т. HARVEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT WILLIAM HILL MANOR EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. JULY 21, 1 9. Birthplace (State or Foreign Country)

W. VA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Months Yrs. 1918 87 Director 213-44-0651 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar mast by notified at 1 ☐ Yes 2 ☐ No Director MD. TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27241 HAYWOOD TRAIL 21601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 þ WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 MANAGER FLORIST STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PARKS JOSEPH TRUBAN MAE VIOLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES E. HARVEY / SON 22665 RIVER RIDGE RD. BOZMAN, MD. 21612 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 permit. Page Department of Importent: If any injury or once. CHESAPEAKE CRM. CTR 9-18-05 STEVENSVILLE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. C.F.S.P. Joseph Ostnowsky m 200 S. HARRISON STREET, EASTON, MD 21601 tenter the mode of dying, such as cardiac or respiratory arrest, Ap 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each [] in . Interval Between Onset and Peath Immediate Cause (Final moruca Physician disease or condition resulting in death) /Medical Due to (or as a con wuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as anding physician and use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for u 1 Live birth 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Meane 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s this certificate 1 Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 10 28a. Date of Injury (Month, Day Yeer) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD M.D. 501 DUTCHMANS LANE EASTON, MD. 21601 31. Date filed (Month Cay 32. E gistrar's Signature State 0 2005 Registrar

		for State Registrar	State	of Marylar		artment of I rtificate of	Health and Death		giene Reg. No2 (05	33185
Physi	cian	1. Decedent's Name (First, Midd			TT- 1	1		2. Date of Dea	ath Day	Year	3. Time of Death
/Med	lical	Betty 4a. Facility Name (If not institution	Jane	number)	па	ley	or Location of Deal	Septemb		2005 ty of Death	11:15 p ^м
Exam	iner	2804 Hewitt		number			Spring	ui		comerv	7
Funera	1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		h	9. Birthola	ace (State or Foreign
Directo		220-28-6136	1 ☐ M 21X F	72	Yrs.	Months Days	Hours Min	Feb. 7	, 1933	Mary1	
D		Usual Residence of Decedent 10a. State 10b. County		100 Ci	ty, Town or Lo	antio n				140	
shov	5	,								10	od. Inside City Limits 1 ☐ Yes 2 🛣 No
the N	Director	Maryland Monto	omery	S	ilver	Spring 10f. Zip Code			10g. Citizen o	f Mhat Count	
with Sa or	Ö		Avenue			20906			USA		
should be filed within 72 hours after death with the Maryland of Mental Hygiene. I wasked other then "neturel", or Items 23e or 28e-f show unatic event, Ite Modical Executarist by nufficient.	Funeral	11. Marital Status	12. Was D	ecedent Ever in U		Was Decedent of	Hispanic Origin? (5	Specify Yes or No-	- 14. Ra	ace - America	
after or Ite	Fur	1 Never Married 2 X Mar	ried 1 □Ye	Forces?	i		oan, Mexican, Puer	to Rican, etc.)		ack, White, e	
ours ours	d by	3 Widowed 4 Divorced	if Yes, Year o	r Dates:		1⊡Yes 2√⊡No	Specify:		Spec	eity: Whit	.e
72 h	Completed	15. Deceder (Specify only highe	nt's Education est grade complete	nd)	(Give	dent's Usual Occu kind of work done	during most of wa	rking	16b. Kind of	Business/Inde	ustry
within ane. then	E D	Elementary/Secondary (0-12)	College	9 (1-4or 5+)		DO NOT use retire	9d)		Danlad		
Hygie ther	ပိ	12 17. Father's Name (First, Middle,	Last)		ban	k Clerk	18. Mother's Na	me (First, Middle,	Banki Maiden Suma	J	
ld be ental ked o	To Be	Clyde Ward					Elsie Ti	•		,	
shound M	-	19a. Informant's Name/Relation:	ship (Type, Print)		19b. Maili	ng Address (Stree	tand Number or R	ural Route Numbe	er, City or Town	n, State, Zip (Code)
alth a		Douglas L. H	Maley/ Hu	sband	2804	Hewitt	Avenue,	Silver	Spring	, MD 2	20906
of He item		20a. Method of Disposition	0 CD	1 .	Place of Dispo	sition (Name of matory or other pla	ace) I	Date Sept. 28	20c. Location	7 - City or Tow	vn, State
Pages nent of I	7	1 Burial 2 Cremation 4 Donation 5 Other (5			rklawn	Memoria	_ ' _	2005	Rockvi	lle. M	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, Ite Marical Exe. Irret mast be notified at	ġ	21. Signature of Funeral Service	Licensee	2	F ?	ancis dedr	esco latins	Funeral			
8055	ă	Mohlu	Xtol	le	5	00 Unive	rsity Bly	7đ, W, Si	llver S	pring,	MD 20901
Physicia		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only orle cause o	at caused the dea n each line. astatic			ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death Year
/Medica	1	resulting in death)	41	to (or as a consec		ша					. ieai
Examine		Sequentially list conditions,	b								
sit ad	luel	cause. Enter Underlying Cause (Disease or injury	Due	to or as a cons	uence of):						
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cate be executed physician and The burial-transit	a E			,	,					- 4	
ficate p phys is the	edical		d								
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn					23d. D	ate of deliver	у
death e atte d for	icia	in the past 12 months?	4□Pre	e birth 2 Feta agnant at time of c]Ectopic pregnanc] Other <i>(specify)</i> _	;у 				Day Year
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w require been si should I								1 🗆 Y	′es 2. ₩ No	3 🗌 Proba	ibly 4 ∐Unknown
e law n has be ge 2 sh	Completed							24a. Was autop		. Were autop:	sy findings available
The ate h	Son							perfor	rmed? 2√□ No	death?	
lcien: The certificate ector, pag	Be (25. Was case referred to medica examiner?						ath (Check only o	ne)		
ding Physicien: The n. n. After this certificate ha funeral director, page	ို	1 Yes 2 No			ER/Outpatier	IL 3 DOA		Home 5 Resid			
ing F After unera	on	27. Manner of Death 1 Natural 5 Pendi	ng (M	te of Injury Ionth, Day Year)	28b. Time o Injury	Wo		28d. Describe h	low injury occu	urred	
ttend death tor: / the f	Certification:	3 ☐ Suicide 6 ☐ Could		co of Injuny - At h	omo farm et	M 1 [Yes 2 No	28f. Location (S	Street and Num	har or Pum!	Poute Number
after Direction by	ertif	4 Homicide determ	nined bu	ilding, etc. (Speci	fy)	eer, ractory, onice		City or Tow	m, State)	IDBI OI HUIAI	Houte (variiber,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	edical C	(Check only 2 Medica	ng Physician: To I Examiner: On the	a basis of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and place	e, and due to the durred at the time, d	cause(s) and m	nanner as sta	ited. the cause(s)
thin 2 the 1 mplet	Med	one) 29b. Signature and tilto of certific	and m	anner stated.		29c. Licen			29d. Date sign		
- × × × 8		250. Signature and title of certific	ノイナ			1	29675		-		6, 2005
OV		30. Name and address of person	- batalamaa adu s	auso of doorh /li-	m 29a\ /Time	Print)					
		Ralph Vincent					rive, #4]	.00, Beth	nesda,	MD 208	17
	tate	31. Date filed (Month, Day, Year		. Aegistrar's Sign	ature	neeles					
Regio		cep 2	2 2005	10.000	KI ES	C Grand					

			1 - For State Registrar	State of Mar	yland		artmen rtificate					Reg. Nd.		33186
	Physici /Medio		Decedent's Name (First, Middle, Last)	CAROL	YN	H	EPD	NG	7		2. Date of De Month	Day	Year S-OS	3. Timb of Death
1	Examir		4a. Facility Name (If not institution, give s CARROLL HOSPITA	-	₹		WE	STMI	Location of	R		4c.	County of Deat	
徽	Funeral Director		5. Social Security Number 6. Sex 216-36-5098	M aNE	in yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (<i>M</i> onth, Da 4 / 7 / 1	y, Year)	Co	hplace (State or Foreign untry) GINIA
	e Maryland 8e-f show	Director	10a. State 10b. County MD CARROL			Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	th with the		1911 PATRICIA (CT.			10f. Zip	Code 2115	8			10g. Citi	zen of What Co SA	untry?
980	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23c or 28e-f show event. I're Medical Evaniner must be rotified at	by Funeral	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	er in U.S	1	Was Deced f Yes, spec 1 ☐ Yes 2	ify Cubar	n, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)	-	14. Race - Ame Black, White Specify: WH	
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)		16a. Decec (Give life. L	dent's Usua kind of wor DO NOT us	k done di	uring most o				nd of Business/	,
	be filed within ital Hygiene. Id other than event, the Me	Be Co	1 2 17. Father's Name (First, Middle, Last)		!				Cles 18. Mother		(First, Middle,		ufactu ^{Sumame)}	ring
Maryland	2 should be and Mental is marked (To	FELIX 19a. Informant's Name/Relationship (Type	MIGUEL			Address	/Stract 2		ARGA		ar Cibra	CARS	
	l and Health om 27 her tr		ALAN E. HEPDING 20a. Method of Disposition 1 \$\overline{9}\$Burial 2 \$\overline{9}\$Cremation 3 \$\overline{9}\$R.	, JR			PAT	RIC	IA C		WESTM	INS		D. 21158
Baltimore,	permit. Pages of Popartment of Pimportant: If ite any injury or of ones.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightse	M	FAD		. Name and	d Address	s of Facility	FLE	TCHER	FU	NERAL	ER, MD. HOME ID. 21157
	Physician	9	23a. Part1. Enter the disease, or emplic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the cause on each line.		. Do not ente	er the <i>m</i> ode	of dying	, such as ca	ardiac or	respiratory ar		TER, P	Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	RT	EN 51 ()~							
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 (4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal	death 3 [Ectopic pre Other (spe					2	3d. Date of deli Month	v ery D ay Year
О.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions con	tributing to death but r	not resul	lting in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did to			the cause of death?
al Records,	: The law recate has be page 2 sho	Completed								_	24a. Was autop perfor 1 Yes	sy	prior to c death?	opsy findings available ompletion of cause of
on of Vital	ding Physicien: The I.h. h. After this certificate ha funeral director, page	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: Inpatient 28a. ate of Injury (Month, Day Y		EP/Outpatient 28b. Time of Injury		Other Bc. Injury Work	. 4 🗆 Nurs	sing Home	Check only one of the control of the	lence 6	i ⊡Other (Spec	ify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At hor Specify)	me, farm, stre					f. Location (S City or Tow		d Number or Ru	ral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in the funeral birection of the funer	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of ner; On the basis of ex and manner stated	amınatı	/ledge, death on and/or inv	occurred a restigation,	it the time in my opi	, date and nion, death	place, an	d due to the o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		///		29c.	License					signed (Month	
_	W5-		30. Name and address of person who con			4.70	Print) C	ARI	3026 2011 H	63 45p	ITAL C		09-26 ER	-05 ER, MD Z1157
	Sta	te	FRANCIS TAT 31. Date filed (Month, Day, Year)	32. Regierar's	Signatu			02	mem	ORIAL	AVE	WE	STENINGS	ER MD ZIISZ
	Registr		SEP 2 7 2	2005	w	K	hours							

		-		artment of Health and Mental entificate of Death	Hygiene 2005 33187
	Dhunini		1. Decedent's Name (First, Middle, Last)	2. Date	of Death 3. Time of Death
	Physicia /Medic		Odie Breeze Hardy		mber 20, 2005 15:45p M
	Examin	er	4a. Facility Name (If not institution, give street and number) Prince George Community Hospital	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of	Prince Georges of Birth (Day, Year) 9. Birthplace (State or Foreign Country)
	Director		337-20-1171 1□ M 2 F 84 Yrs.		n, Day, Year) Country) 23, 1920 Rome, Ms.
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I.	ocation	10d. Inside City Limits
	Maryl -f sho	tor	Maryland Prince Georges Capito	l Heights	1 ∰ Yes 2 □ No
	or 28a	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wi	rai	1207 Addison Rd.	20743	United States
	ltams	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 12 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.
036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Modical Examinat monthe modified at	by	3 ¼ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
5-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation s kind of work done during most of working	16b. Kind of Business/Industry
121	within one. than *	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	Private
d 2	filed withii Hygiene. othar than ant, Ite M		12 Caf	eteria Manager 18. Mother's Name (First, M	iddle, Maiden Surname)
/lan	2 should be filed withir and Mental Hygiene. Is marked othar than sumatic evant, Ite M.	To Be	Judge Griffin	Ruby Cade	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. itam 27 Is marked other than "naturat", or Itams 23a or 28a-f show other traumatic evant, Ir. McJica Evanities from the rolling at			ing Address (Street and Number or Rural Route N	
	1 and 2 Health tam 27 l			Ocala Ave. District He	20c. Location - City or Town, State
mor	Pages nent of I ant: If its ary or o		15D Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Ft. Lin	osition (Name of place) coln Sept.29,20	005Brentwood, Md.
Baltimore,	permit. Pages 1 and Department of Health Important: If itsm 27 any injury or other tr once.	Ì	21. Signature of Funeral Service Licensee	2 Name and Address of Facility Alexander S. Pope Fune 5538 Mariboro Pike/Fore	
			23a. Parf1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.		
	Pnysician		Immediate Cause (Final disease or condition	ration	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	(
		ē	if any, leading to immediate Due to (or as a consequence of):	otion	
	outed ansit	Examiner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
,00	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
8760,	eath certificate be execu attending physician and for use as the burial-tra	dical	d		
Вох 6	nding use at	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
P.O.	that the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
of Vital Records,	uires tha signed I	d by	Hx a Colon cancis		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Miknown
000	law requir as been si 2 should	piete	Ashites		Was an 24b. Were autopsy findings available
Re		Completed	Nighter Mullitus	101	autopsy prior to completion of cause of death? /es 2 No 1 Yes 2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check of	
of	Physician: this certificatal director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 2. ☐ EP/Outp		Residence 6 Other (Specify)
ou	iding I th. : After i funer	tion	27. Manner of Death 1 Datural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work? M 1 □ Yes 2 □ No	The now injury occurred
Division	il or Attandi after death. Diractor: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Locat	ion (Street and Number or Rural Route Number, or Town, State)
D	pital o				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the i	time, date and place, and due to the cause(s)
	To the Comp	Ň	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Λ			20 Needs and addrags of payers who completed a very old death (less co.) 7	DOU 43662	9/20/05
	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type N (MAM BOY(E PC) + to ()) +	a/ 3001 Hospital D	e. Cheverly md.
	Sta Registr		SEP 2 9 2005	te	

	V 16		1 - State Registrar 1. Decedent's Name (First, Middle, Li		Maryland			nt of H te of L		Mental H	Reg. No	2000	33188
	Physici /Medic Examin	al	Robert 4a. Facility Name (If not institution, gi	Murray	Hu:	nt :	LII 4b. Cit	y, Town, or	Location of Dea	Septen		30, 2005 County of Death	12:00 p.m
\$	Funeral Director	100	220-16-7792	orial Ho Sex 7	spital Age (In yrs. Ia 79	is <i>t birthday)</i> Yrs.	If Und Month	er 1 Year	nce Free If Under 24 Hrs Hours Min	S. 8. Date of E	Day, Year,	Calve 9. Birth Cou	place (State or Foreign ntry)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, if a Madical Example Learning Learning and Once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland St. Ma 10e. Street and Number 46386 Fletc 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest girle) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las Robert Murr 19a. Informant's Name/Relationship Virginia W. Hunt 20a. Method of Disposition 1 Burial 2 Cremation 3 Secure All Donation 5 Other (Special Signature of Funeral Service Lice) Kyle S. Simo	her Court 12. Was Deced Amed Forc 1 Yes. 2 If Yes, Give Year or Date ducation ade completed) College (1-4 t) Ay Hunt, (Type, Print) Wife Removal from St fy)	ant Ever in U.S as? □ No as: □ No as: □ 20b. Pla cei	16a. Deced (Give life. Ca 19b. Mailir 46386 ace of Dispo watery, crer yland	Was Decilifyes, sp. 1 Yes dent's Us kind of v DO NOT ar Do Sition (N matory of Veto Name	edent of Hierory 20 No ual Occuperory Cuba 22 No ual Occuperory done a use retired use retired eater ss (Street a use of other place et che ame of other place and Addres and Addres	Specify: ation bring most of wo 18. Mother's Na Maria and Number or For Court, Cem 10- s of Facility Br	Specify Yes or Note Rican, etc.) orking The (First, Midd) E. Green The Inval Route Num Date -5-2005 rinsfiel	Uni 16b. F 16b. F 10c. L ted Stat 14 Race - Amening Black, White, Specify: Whi Kind of Business/In Automot Surname) 1 Or Town, State, Zig Park, Ma: Jocation - City or Townsville neral Hor	es can Indian, etc. te idustry ive Code 20653 ryland own, State MD	
68760,	bhysician and physician and physician and physician and physician as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undernin Cause (Disease or injury that initiated events resulting in death) Last	a. Hepati Due to (or b. Metast Due to (or	th line. .c Coma as a conseque	ence of): lenoca ence of):			g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
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ords, P	requires tha	by	Part II. Other significent conditions Acute Renal Fai		h but not resul	ting in the u	nderlying	cause give	n in Part I.		tobacco Yes 2	22	he cause of death?
Vital Record	The la	e Completed	25. Was case referred to medical						OC Plane of Da	per 1□ Yes	opsy formed? 2 Ro	prior to co. death?	posy findings available impletion of cause of
Division of Vil	ding Phya h. After this funeral dii	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not	pe 28e. Place of	Injury Day Year)	R/Outpatien 28b. Time of Injury	М	28c. Injury Work	r: 4 🗆 Nursing I	28d. Describe	sidence how inju	nd Number or Rura	
Ď	Hospital or 4 hours afte Funeral Dir ely filled in b		29a. Certifier 1 Certifying P	hysicien: To the bas	s of examination	ledge, death	1 occurre	d at the tim	e, date and plac	e and due to th	e cause(s	and manner as s	tated.
)	To the within 2 To the Complete	Medical	29b. Signature and title of certifier	and mayine	stated.		2	9c. License	number		29d. Da	ate signed (Month,	
1) Sta Registr	- 6	Yvonne Lee, 110 31. Date filed (Month, Day, Year) OCT 4 200	Hospital 32. Reg		Suite	310,	Prin	ice Fred	erick,	Mary]	land 2067	78

			Please Type or Print in black indelible ink. Ensure All Copies Are Legible.	
			State of Maryland / Department of Health and Mental Hygiene 2005 3318 Certificate of Death State of Maryland / Department of Health and Mental Hygiene 2005	39
		-	Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	1
	Physici		Kemp Harris JR, SEPTEMBER 23 2005 0842 A	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER	
	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min. (Month, Day, Year)	ign
	Director		220-28-4690 12M 20F 73 Yrs. Months Days Hours Min. (Month, Day, Year) 932 Maryland Usual Residence of Decedent	
land	MOI		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	its
) Mag	B-f s	tor	MD Dorchester Woolford	No
) ₹	or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
death with the Maryland	23a		4645-Harrisville Road 21677 USA	
, ē	Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	
-0036 v	o', or	by	3 □ Widowed 4 □ Divorced Specify: 1 □ Yes 2 ☑ No Specify: Specify: Specify:	
15-0036	"neturel", or items 23a or 28a-f show coloui Examinar mast be notified at	Completed	15, Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry	
- CLZT : within 72	han "	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	
O N	tal Hygiene. d other than "netu event, Ire Medical		10 Maintenance Mechanic Seafood rocessis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	29
d be		To Be	Kemp Harris SR. Sarah Chester	
Maryland d 2 should be file	th and Menta 7 Is marked traumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	. 10
_ č	fealth a		Lovella Flaine Harris 4645-Harrisville Rd. Woolford, MD. 21677	
altimore,	of a signal of a s		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lovation - City or Town, State	
IIMOr Pages	ortant: ortant: injury o		"4 Donation 5 Dother (Specify) Malone Cemetery 10/1/05 Mad: Son Marylan	d
Balt Permit.	Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A.	,
			Tomelle C. Alway 1510 washing ton St. Cambr. de e MD. 2/6/2 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between)
Di	ysician		Immediate Cause (Final	
1	Medical		disease or condition resulting in death) Due to (or as a consequence of):	P
E	caminer		Sequentially list conditions. b	
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rtificat	ng ph) as th	-	IE ECHALE.	
Box eath cert	attending pl	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	
o at	the a	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown	
Ja ja	been signed by the should be detached	/Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Records, he law requires t	n sigr Jd be	ed by	DMIL CAROTIO SFUNGSU 1 Tes 2 No 3 Probably 4 Unknow	wn
aw re	s bee 2 sho	Completed	24a. Was an autopsy findings availat autopsy prior to completion of cause of	ble
	ate ha	mo	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No	и
Vital ticien: T	artific actor,	Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
<u> </u>	this certificate has ral director, page 2	2	1 Yes 2 No	
on ding	h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28b. Time of Injury Work?	
DIVISION OF 1 or Attending Phy	ector by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,	
	el Dir ed in	Certification:		
Division of Vita To the Hospital or Attending Physicien:	within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical	29a. Certifier (Check only Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
o the	ithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of partifier 29c. License number 29d. Date signed (Month, Day, Year)	
ř	\$ ⊢ ŏ		D42816 9/23/05	
			30 Name and address of person with completed cause of death (Item 23a) (Type, Print)	\neg
			R.A. Burgoyne 555 Cynucol On EASTUN MO 21601	
	Sta Regist		31. Date filed (Month, Dat Start) 2 7 2005 Registrar's Signature	

			Other of Maniand / Density and of Health and	
			State of Maryland / Department of Health and	Mental Hygiene
			Registrar Certificate of Death	Reg. No. 0 0 5 33 90
	Physicia	an	1. Decedent's Name (First, Middle, Last) Seaven Nontra Wesley Jones	2. Date of Death Month Day Year 3. Time of Death
	/Medic		75,000 (80.0)	09 21 2005 11:20pm
	Examin	er	4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Dea	
			Memorial Hospital at Easton Easton, M	11) labor
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min	
	Director			- 9/21/05 MD
	pue *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	sho	ក	MD DORCHESTER VIENNA	1 □ Yes 2 XNo
	the A	ect	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	with	ᅙ	4844 DAFAN (-430) 01 2016	(SA
	eath	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
	iter d	5	Armed Forces? If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.) Black, White, etc.
39	irs ef	by F	1 ☐ Yes 2 ☐ Married 2 ☐ Married 1 ☐ Yes 2 ☐ Morried 1 ☐ Yes 2 ☐ M	Specify: Black
21215-0036	filed within 72 hours effer death with the Marylend Hygiene. vther then "naturel", or Items 23a or 28a-f show ont, the M. dicel Examirer must be notified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
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212	with iene	E	Elementary/Secondary (0-12) College (1-4or 5+) Not a pplicable	not applicable
ਹੁ	Hyg othe	BeC		me (First, Middle, Maiden Sumame)
au	ld be enta ked ic ev	To B	Taron Dontra · Anderson Leos	ha Moriace Jones
Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Examiner must be notified at once.	-		Rural Route Number, City or Town, State, Zip Code)
Š	nd 2 ulth a 27 is r tra		Leosham. Jones/mother 4844 Ocean 6	Fareway Vienna MB 21869
ē,	Hea Hea tem othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
no	ages ant of t: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR	0/22/2005 CTEVENOVILLE NO
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	9/23/2005 STEVENSVILLE, MD
Ba	perm Depa impo any i		FELLOWS, HELFENBER	IN & NEWNAM FUNERAL HOME PA
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	Le EGOLUN, MU ZIOUI
			shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a	
В	/Medical Examiner		Due to (or as a consequence of):	
ko		L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	ad sit	lne	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	
	and and -tran	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):	
760,	ate ba exacuted hysicien and the burial-transit		bus to (or as a consequence or).	
87	cate l	dical	d	
x 68	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE:	
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year
0	e de the a	SIC	1 Yes 2 No 9 Unknown 9 Unknown	
<u>Ф</u> .	d by	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Ś	res the		Tatt it. Other significant continuous continuous to death but not resolute in the underlying cause given in Fatt it.	1 Yes 2 No 3 Probably 4 Unknown
ord	w require baen sig should b	ted		TE TES 20010 SETTODADIY 4 CONNOVIT
ec	a 8 0	Completed		24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of
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Division	Attending r death. ector: After by the fune	atle	2 Accident investigation M 1 Yes 2 No	
<u>×</u>	or Attendate death	tiffic	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
۵	tel or A rs after al Dire ed in b	Certification;		
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occ	te, and due to the cause(s) and manner as stated.
	in 24 in 24 ihe F plete	ed	one) and manner stated.	
	To T To T	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Monthy Day, Year)
)			Mehelet M.D. MD D5850	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n, my 21601
		1	Michael Judy 506 Idlewild Ave East	n. my 2160)
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 6 2005	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 00Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sept 24, 2005 23:19 BESSIE ELIZABETH JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 4, 1925 **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 🗗 Months Hours Yrs. 578-54-9522 80 Director Maryland Usual Residence of Decedent Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Madical Exactiner cost be notified at 1 Yes 2 No Completed by Funeral Director MD Silver Spring Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with ö 20910 2205 Michigan Ave or Items 23a U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Day Care Center and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ralph Carter Martha Edna Brown P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zabrina Johnson-Department of Health Importent: If Item 27 2205 Michigan Ave Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/27/05 Metro Fnrl Svcs Alexandria, VA ^ 4 □Donation 5 □ Other (Specify) 21. S nature of Funeral Service Lice see 22. Name and Address of Facility Snowden Funeral Home, P.A. any in 246 N Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ASYSTOLE disease or condition resulting in death) 5mins /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST 10 mins Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CORONARY ATERY DISEASE or Attending Physicien: The law requires that the death certificate be executed burial-transit 15YRS and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown á s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2⊠No 2 No 1 Yes 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient X DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 XNatural after death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 T Homicide within 24 hours a
To the Funerel I
completely filled filled Fo the Hospitel 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Sept 26, 2005 D23805 2 0 2022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Rd Silver Spring MD 20910 MD Daniel Woronow, 31. Date filed (Month, Day, Year) SEP 2 8 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death . Decedent's Name (First, Middle, Last) September 27, 2005 **Physician** James Jovner 6:08A. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4411 Romlon Street Prince George's Beltsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) Feb. 9, 1935 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 XM 2 ☐ F Florida 262-46-8103 70 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene.

criant: If item 27 is marked other then "naturel", or items 23e or 28e-f show injury or other treumetic event, the Medical Examiner must be notified at a second or the model. Beltsville Prince George's 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4411 Romlon Street 20705 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 ð 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James W. Joyner Myrtice Rose Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4411 Romlon Street Beltsville, Maryland 20705 Shirley A. Sundstrom-Joyner/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State permit. Page Deportment of Important: If any injury or Metropolitan Crematory 9/29/2005 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1month Pnysician Liver Failure /Medical Due to (or as a consequence of): **Examiner** Metastatic Small Cell Cancer 6months Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Manner of Death Certification: After t Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel of within 24 hours are To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35996 September 28, 2005 ellma 12 D. 2730 University Blvd.,#400 Wheaton, Maryland 20902 30. Name and address of person who completed Linda M. Burrell, M.D. \$2. Registrar's Signature 31. Date filed (Month, Dav. Year) State SEP 28 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 33193 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26, Sept 2005 7:10A LUCILLE JONES **JENNIFER** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nov 8, 1956 7. Age (In yrs. last birthday) 48 9. Birthplace (State or Foreign **Funeral** 1 □ M 21 □ F Trinidad **Director** 068-62-9780 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Experiment that be notified at Wheaton 1 Yes 2 No MD Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2030 Georgian Woods Pl # 43 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) The Hebrew Home Nurse Aide 12th permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important; if Item 27 is marked other it
any Injury or other traumatic event, ID
DDRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Jones Garland Noel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2030 Georgian Woods Pl #43 Wheaton, MD20902 19a. Informant's Name/Relationship (Type, Print) Christine Jones- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 10/3/05 Silver Spring, MD Gate Of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Licensee 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 080 hours /Medical Due to (or as a consequence of) Examiner 10 yrs. failure Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Sustenic 10 445 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstrctive cardionyopany 1 Yes 2 No 3 Probably 4 Unknown Completed thrombo agto penia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an Aneulia 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hippatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t s after de-ral Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 29 2005

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September 20,2005

Pince Phillip Dr. dueg M20832

			For State Registrar	State of N	Maryland				ealth a				200	5	33194
			Decedent's Name (First, Middle, Last)								2. Date of Dea	ath		ear	3. Time of Death
	Physici: /Medic		Martha R. Jaquet	te							Month		4 201	05	8:20 PM
7	Examin		4a. Facility Name (If not institution, give	street and numbe	r)		_		Location of	of Death		4c.	County of		
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	Funeral Director		5. Social Security Number 6. Sec 222-05-4228]м 2 5 Дг	Age (In yrs. Ia 90	Yrs.	Months	Days	Hours	Min.	(Month, Da	5,19	915	Coun	ace (State or Foreign try)
			Usual Residence of Decedent								100.	J / I -	, 1 0		
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12	filed w Hygien othar tl		11. Father's Name (First, Middle, Last)			T.	reas	urei		er's Name	(First, Middle,			ice	Agency
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Maryland	s 1 and 2 should be it Health and Mental Itam 27 is marked oothar traumatic eva	၉	19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address	s (Street a			Route Numbe		r Town, Sta	ate, Zip	Code)
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ore,	ss 1 ar of Hea Itam 2		20a. Method of Disposition	Damassal from Cha	l ce	ace of Dispo	sition (Na.	me of other plac	e) !	D	ate	20c. Lo	cation - Ci	ty or To	wn, State
altimore,	Page nent c ant: If		1 → Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)		" Gi	1pin	Man	or		Sept	. 28,	2005	5 E1	(to	n, MD
alt	permit. Pages 1 Department of He Important: If Itan any injury or oth		21. Intrature of June range of Licens	ee		22	Name ai	nd Addres	s of Facili	ee F	unera	1 нс	ome		
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rds	quires n sigr ald be	ed by	HYPERTENSION								10	Yes 2	□No 3	☐ Prob	ably 4 Unknown
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ita	ysiclan: Th iis certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Plac	e of Death	(Check only o	one)			
of V	S D	2	1 □ Yes 2 No	Hospital: 1 🗆 Inpa		ER/Outpatier			400		ne 5 Resid				")
	ding P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time o Injury	м	28c. Injun Worl	∤at k? Yes 2. [8d. Describe	now injur	y occurred		
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Ď.	l or Attancafter death Diractor:	ertif	4 Homicide determined	building,	etc. (Specify	')	001, 140101	, 011100			City or To	wn, State)		
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	5		30 Name and address of/person who c	ompleted cause of	of death (Item	23a) (Type.									
			RODNEY DONAAM.	D.O. 18	of death (Item 81 TE) istrar's Signal	EGNAF	24 R	, OAO	KISH1	LOOP	MD ?	11911			
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State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day AZAZEL Αм JIMENEZ AUG 2005 /Medical 10:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months **1**X M 2 □ F Director AUG 19 2005 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Moulcal Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No MARYLAND MONTGOMERY wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1970 LA POINTE DRIVE 20902 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: þ 3 Widowed 4 Divorced Specify: PUERTO RICAN WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FELIX JIMENEZ 2 ZAHIRA MEDINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZAHIRA MEDINA/MOTHER 1970 LAPOINTE DRIVE WHEATON MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4. ■Donation 5 Other (Specify) 9/28/05 NAME BETHESDA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Him (from BETHESDA NAMIC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician EXTREME PREMATURITY (18 wks) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2□ No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2XNo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Morrage MD 0101052964 (VA) 8/19/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER CHRISTOPHER H. REED LCDR USN BETHESDA MD 20889-5600 MC32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 3 2005 Registrar

			For	State of Mar		Depa		lealth a		ental Hyg		9		
			Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath (2000	Этідь с	Death
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	/Medic Examin		4a. Facility Name (If not institution, give NATIONAL NAVAL		NTER		4b. City, Town, or BET	Location of				. County of Death MONTGO	MERY	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene importent: it item 27 ie marked other then "neturet", or Items 23a or 28a-f ehow emprising or other traumetic event, the Medical Evant and the modified at once.	by	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:			1⊠Yes 2□No				AN	Specify: W	HITE	
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0	H		30. Name and address of person who	completed cause of de	ath (Item 23a	a) (Type,				L MEDIC				
B.	1.		CHRISTOPHER H. RE	ED LCDR	MC US	SN				0889-56				
	St Regist	ate rar	31. Date filed (Month, Day, Year) 3	2005 32. R distra	r's Signature	4 /	goods							

Carmen Jeffery 05-0 RPD

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O**v**e**t**a Jones 05-06547 NJM

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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation							10d. Inside City Limits	_
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9	"natural	ed b	15. Decedent's E	Year or Dates:	110	6a. Deced	ient's Usua	al Occupa	lion			16b K	ind of Business/li	ndustry	
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yla	D = 2 0	ို	Charles Jones								McCain				
Maryland 21215-0036	T L		19a. Informant's Name/Relationship (Dary1 Jones/Son	Type, Print)	101		_				uitlan:		or Town, State, Zi	-	
e,	s 1 and 2 if Health item 27 othsr tre		20a. Method of Disposition		20b. Place	of Dispos	sition (Nan	ne of			ale		ocation - City or T		-
mo	0 0 = =		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				natory or o Iemor		´ _	ept.	30,20		Landover		
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g .			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that cause	d the death.	o not ente	er the mod	e of dying	, such as				TID: 20	Approximate Interval Between	_
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$_{\Lambda}$			Thursday M.	King um	2			OCM	E			Septe	ember, 2	6, 2005	
K	(10)		30. Name and address of person who		death (Item 23	а) (Туре,	-	1 1	C.		D 1		3.5	1 01001	
	0		THE COOKE Myke, 31. Date filed (Month, Day, Year)		rar's Signature		11	T Lei	nn St	reet	Balt	1more	e, Maryl	and 21201	
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	e Maryland a-f show ilfied at	ctor	10a. State 10b. County MD Dorche		Oc. City, Town or		ambridge			10d. Inside City Limits 1 XYes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 1619 Stone Boun	dary Road		10f. Zip Code	21613	10g.	Citizen of What Cou USA	ntry?
9036	d within 72 hours after death with the Maryland jone. Ir than "netural", or Items 23a or 28a-1 show It a Madical Examiner inust be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1	946-54	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 📈 No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
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Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signatur Funeral Service Licen) I		sposition (Name of rematory or other pla Veterans 22. Name and Addre	Cem 9,		Murlock, Meral Home	D
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Divis	al or Attendi s after death of Diractor: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, s	street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rura. ate)	Route Number,
	he Hospital in 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 ★ Certifying Phy (Check only on#)	rsician: To the best of m iner: On the basis of exa and manner stated	imination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
)	To the To the To the Complet	Σ	29b. Signature and title of a stiffier	1		29c. Licens			Pate signed (Month, l	
			30. Name and add ss of person who de Mary Jo Hatey, M.	D. 22'	South	e, Print) GVLLIU	Stree	t Balto	, MD	21201
1	Sta Registr	- 41	31. Date filed (Month, Day, Year) SEP 2 7	2005 32. Registrar's	Signature	Cools				

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 23a, PtI, II, 25, 27 28 To Leave ME 6349, 11/29/05dh 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ROBERT J. KLUNK SEPTEMBER 23, 2005 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore Hours Min. 8. Date of Birth Month. Pay. Year 08 / 14 / 1931 If Under 1 Year Months Days Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 ☐ F 205-07-0515 74 Yrs. PA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumstic event, the Medical Examiner triust be notified at 1 XYes 2 No MD Directo BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1040 DEER RIDGE ROAD, APT 302 21210 U.S.A. death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 11♥ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 文No Specify: Specify: WHITE δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be fili partment of Health and Mental Hy portant: If Item 27 is marked oth y Injury or other traumatic event Be EUGENE L. KLUNK CATHERINE C. RISER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYRIL F. KLUNK - BROTHER 347 RIDGE AVE. MCSHERRYSTOWN, PA. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition PA | Survival 2 | Cremation 3 K Removal from State | Community of the Communi permit.
Departr
Imports
any Inju 21. Signature of Funeral Service Licensee MYERS-DURBORAW FUNERAL HOME M01191 91 WILLIS ST. WESTMINSTER, 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR THROMBOSIS **Physician** /Medical Due to (or as a consequence of) Examiner SUBBURAL HEMATOMA-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER CENEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Subdural hematoma, hypertesnion, pneumonia should I Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s 2 X No 1 ☐ Yes 25 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 1 X Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ➡No Probable fall 2 Accident 3 Suicide Unknown Director: Unknown 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Unknown Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated Med 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number melle SEPTEMBER m.O 2105. WIL 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 JOGINDER P. MEHTA M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) SEP 2 32. Registrar's Signature State 2 6 2005 Glow to Specie Registrar

ALBERT JAMES KING Jr. 05-06516 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 24,2005 **Physician** 1:59A. Albert James King Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6/28/1973 Birthplace (State or Foreign
Country) **Funeral** 1₩ 2□ F Months Days Hours Min 220-78-6851 32 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow 27 is marked other than "natural", or iteme 23a or 28a-f ebov traumatic event, its Modical Examinar must be multified at Maryland Wicomico Fruitland 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 753 S. Camden Ave. 21826 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant; if Itam 27 is marked of albert James King Sr. Virginia Sue Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Sue Hurley/mother 753 S. Camden Ave., Fruitland, MD 21826 itam 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important; if it any injury or o Springhill Memory 1 Burial 2 Cremation 3 Removal from State 9/29/05 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD Gardens 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Lice Cutt 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

> □ □ No page 2 s hes Vital Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 TYPes 2 □ No Division of this 28d. Describe how injury occurred wellife 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Declased In ver 5 Pending investigation 1 Natural Injury s efter des rel Director; Aft to the fi -24-05 1:37 AM 1 Yes 2 No quandrail art tall 2 Accident soruck 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) A LIEN Zocica 4 Homicide

n 24 hous. the Funeral Directory filled in Medical completely To the within 2

State Registrar 29a. Certifier

one)

29b. Signature and title

31. Date filed (Month, Day, Y

of

6 Could not be determined

28e. Place of Injury - At home, farm, sweet, factory, office building, etc. (Specify)

Somer sot, wilconumo 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

111 PENN STREET BALTIMORE MARYLAND 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) SEPTEMBER 24,2005

30. Name and address of person of geath (Item 23a) (Type, Print)

2005

H. Aprile

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005

			For State Registrer	State of	Marylan		artment of H		and Men		ene2 () ()	5	33203
	Diii		1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Y	'ear	3. Time of Death
	Physici /Medio		JAE-KOO KIM							eptembe	er 24,		11:59₽
	Examir	er	4a. Facility Name (If not institution, give		nber)		4b. City, Town, or		f Death		4c. County of		
_			9809 Woodford Ro 5. Social Security Number 6. Se		7. Age (In yrs.	last hirthday)	Potoma If Under 1 Year		24 Hrs. 8 F	Date of Birth	Montg		e (State or Foreign
	Funeral Director			M 2□F	7. Age (111 y/3.	Yrs.	Months Days	Hours	Min. (/	Date of Birth Month, Day, Y	1933 I	Country)
			Usual Residence of Decedent							20,	1733 1	torea	
	ylanc		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d.	Inside City Limits
	a Ma 3a-1 s	cto	Maryland Montgome	ery	Po	tomac				1			1∑Yes 2 No
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Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?							eck only one)			
of \	hysio this c	မ	1 195 22,110		-	ER/Outpatier					ce 6 Other		
n c	ling F	ion	27. Manner of Death 1 XNatural 5 ☐ Pending	(Mont	of Injury h, Day Year)	28b. Time o Injury	Wor	yai k? Yes 2.⊟1	1	Describe now	injury occurred		
isi	Attending r death. actor: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place	of Injury - At h	ome farm sti	eet, factory, office	163 2		Location (Stree	et and Number	or Rural R	oute Number.
Division	after after Dirac	Certification:	4 Homicide determined	buildir	ng, etc. (Specif	y)				City or Town, S			
	Hospita 4 hours Funaral ely fillec	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	ner: On the ba	best of my knows	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and o th occurred at	due to the caus t the time, date	se(s) and mann and place, and	er as state d due to the	ed. e cause(s)
_	To the within 2 To tha complet	Me	29b. Signature and little of pertifier		1///		29c. Licens	e number		29d	l. Date signed (Month, Day	y, Year)
	20			///	/ 6		D003	3293		2	Septemb	er 26	, 2005
	V	- 1	30. Name and address of prison who	mpleted caus	e of death (Item	п 23а) (Туре,	Print)	1.0	7,0		-	- 100	
			Frederick P. Smit					Aven	ue, #1	300, Cl	nevy Cha	ase,	MD 20815
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 8 20	32.	egistrar's Signa	iture	eli						

_			1 - For State Registrar	State of Maryla		artment of Hertificate of D			giene eg. No. 2005	33204
	Physici /Medic		1. Decedent's Name (First, Middle, La Emory R. Ko	of, Jr.				2. Date of Dea Month Sept.	23, 200	5 1753 ^M
	Examir Funeral		,	Medical Cen	ter s. /ast binthday)	If Under 1 Year	nnapoli If Under 24 Hrs.	S 8. Date of Birth (Month, Day	4c. County of De	e Arundel irthplace (State or Foreign
Ť.	Director		217-34-8769 Usual Residence of Decedent 10a. State 10b. County	128M 2□F 69	Yrs.	Months Days	Hours Min.	June 8		MD 10d. Inside City Limits
	the Mary 28s-f eho	Director	MD Anne	Arundel		Arnold		1 1	0g. Citizen of What (1 ☐ Yes 2 🙀 No
	23a or	rai Di	1283 Terrace La			2	1012		US	A
9000	2 hours after death with the Maryland etural', or iteme 23e or 28e-1 ehow ical Exemiter case be notilied at	d by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	If Yes Give	957– 961		Specify:	ecify Yes or No- Rican, etc.)	14. Hace - An Black, Wh Specify:	nerican Indian, hite, etc. White
21215-0036	I within 72 iene. r then "ne	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupati kind of work done du DO NOT use retired) raffic Cor	ring most of work	ing	16b. Kind of Busines	s/Industry Government
Maryland 2	should be filed ind Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Las Emory R. Kopf,				Elsie I	Harbaugh		
Mar	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship Steven Kopf/Son	(Typa, Print)		ng Address (Street an Onifer Lar				Zip Code)
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Spec	☐Removal from State	cemetery, crer	esition (Name of matory or other place) rematory		26, 005	20c. Location - City of Baltimore	
Balt	pernit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Line	nsee July M	2 B 4	arranco & 95 Gov. Ri	Sons, P.	A. Seve	rna Park I rna Park,	Funeral Home MD 21146
	Pnysician /Medical		23a Fart1. Inter the disease, or cor shock, ir heart failure. List only trimediate cause (Final isease ir condition	nplications that caused the dea y one cause on each line.	Coll	er the mode of dying,	such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Deat
8760,	le be executed ysicien and burial-transit eburial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfung Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.		æ				J mouth
P.O. Box 6	the death certify the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of d Month	alivery Day Year
	sign sign d be	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause given	in Part I.	23e. Did tot		to the cause of death? Probably 4 □Unknown
al Records,	The ate ha	Completed	<i>σ</i>	O .				24a. Was a autops perform	y prior to death?	autopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: 1 within 24 hours effer death. To the Funerel Director: Affer this certifica completely filled in by the funeral director.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 28c. Injury a Work?	4 Nursing Ho	me 5□Reside	e) once 6 Other (Sp ow injury occurred	ecify)
Divis	tal or Attend rs efter death ef Director: /	Certification:	3 Suicide 6 Could not a determined		home, farm, str hify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F 1, State)	Rural Route Number,
	To the Hospital within 24 hours e To the Funerel Completely filled	edicai	29a. Certifier 1 ★ Certifying P (Check only one) 2 ★ Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time, vestigation, in my opin	, date and place, nion, death occurr	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	ge NO		29c. License r			9d. Days signed (Mor	oth, Day, Year)
			30. Name and address of person who	completed cause of death (Ite	om 23a) (Typa.	Print) Reduse P	a. Keep.	Soche 3	to Ar	ne fot
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2	32. Registrar's Sign	nature	and .	9			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	arylan	-	artment rtificate			and Me			2005	33206
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Leilani A. Lovern		., ,,,	7 78-2	_				Date of Deat Month Sept		Yeer 2005	3. Time of Death 0755 A M
	Examir		4a. Facility Name (If not institution, give s 12419 Loretta Rd.,	, Apt. 2			Prin	nces	Location o	of Death		4c. C	ounty of Dea	ıth
	Funeral Director		5. Social Security Number 6. Sex 218-36-6141	7. Aq	64	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day, ay б, 1	Year) 1941		thplace (State or Foreign ountry) MD
	he Maryland 8a-f show otified at	Director	10a. State 10b. County MD Somerset			y, Town or Lo incess								10d. Inside City Limits 1X Yes 2 □ No
	th with the 23s or 2	ai Dir	12419 Loretta Rd.,	Apt. 2			10f. Zip (^{Code} 21853	3		10		on of What Co	ountry?
036	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Wedical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:)	11	Vas Decede f Yes, speci I ☐ Yes 2		spanic Orig n, Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		Black, White Processing No. 10	
Maryland 21215-0036	within 72 hc ene. than *natur tis Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or	5+)	16a. Deced (Give life. L	kind of work DO NOT use	k done d	uring most	of working		16b. Kind	of Business	/Industry
/land 2	ould be filed Mental Hygic arked other atic event, tt	To Be Co	17. Father's Name (First, Middle, Last) Eldon Clark				110	-	18. Mother	r's Name (F	First, Middle, N	Maiden Si	n/a umame)	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 le marke any injury or other traumatic. ODC®.		19a. Informant's Name/Relationship (Typ. Cindy Jones/daught 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Source License	er		12419 lace of Disposemetery, cremematory	Lore sition (Name natory or off D	tta e of her place elma	Rd.	Apt. Date 0/26/2	Poute Number, 2, Pri	nces 20c. Loca Delm		MD 21853 fown, State
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as	a consenu	n. Do not ente	18 We	st R of dying	d s	Salish	urv. M	D 21	801	Approximate Interval Batween Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examine	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as	a consequ	uence of):								
.O. Box	at the death certific by the attending p tached for use as i	Physician/Me	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 [Ectopic pred Other (spec					230	d. Date of del Month	ivery Day Year
rds, P.	signed signed d be de	by	Part II. Other significant conditions conf	tributing to death b	ut not resu	ilting in the un	derlying cau	use givei	n in Part I.			accouse		the cause of death? obably 4 <u>Unknown</u>
al Records,	The ate h page	Completed									24a. Was an autopsy perform	,	24b. Were au prior to death? 1 Yes	topsy findings available completion of cause of 2 No
Division of Vital	al or Attending Physician: after death. I Director: After this certific d in by the funeral director.	ertification: To Be	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	ry y Year) ury - At hor	ER/Outpatient 28b. Time of Injury	286 M	Other c. Injury Work?	r. 4 □ Nurs	sing Home 28d	5 Resider Describe how	nce 6⊡ vinjuryo	ccurred	ral Route Number,
בֿ	To the Hospital or within 24 hours after To the Funeral Director Completely filled in Its	edical Cert	29a. Certifier (Check only 2 Medicel Examin	er: On the basis of	of my know	vledge, death	occurred at	the time	e, date and nion, death	place and	City or Town,	State)	d manner as	etated
)	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta	NEG.		29c.	License				d. Date s	igned (Month	n. Day, Year)
	tal		30. Name and address of person who con	npleted cause of d	eath (Item	23a) (Type, P	Print)	Sar	ad E	3ara	MD	218		
	Sta Registr		31. Date filed (Month, Say, Year) 7 20	05 32. Registra	ar's Signati	Ure A	hast.	,						

			1 - For State Registrar		partment of Health and Nertificate of Death		ene
**	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gilbert	Lake		2. Date of Death Month	
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St.Mary's
Ī	Funeral Director		5. Social Security Number 6. Sec			8. Date of Birth (Month, Day, Dec. 18	Birthplace (State or Foreign
	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28e-f show the Medical Exercit at retires be restilled at	Director	10a. State 10b. County Maryland Dorches	10c. City, Town or	Location		10d. Inside City Limits 1 □ Yes 2.
	eath with th		10e. Street and Number 4785 Skeet Club 11. Marital Status		10f. Zip Code 21643		g. Citizen of What Country?
980	ours after d rei', or item Exertite	I by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1. Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 D No Specify: 	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23s or 28e-f show any injury or other treumatic event, it whe lied Exercit with retributed at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) (Given by College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ring	6b. Kind of Business/Industry
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Edgar	Lake		e (First, Middle, Ma Collins	
	and 2 sho lealth and N m 27 is ma			iece 91:		mbridge,M	aryland 21613
Baltimore,	it. Pages 1 irtment of H irtent: if ite njury or ot		20a. Method of Disposition 1 △Burial 2 ☐ Cremation 3 ☐ F 1 △ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens.	MD VETER	ematory or other place) RANS CEMETERY Sept		DC. Location - City or Town, State HURLOCK, MD
Ba	permi Depa impo		Dammie S	cations that caused the death. Do not en	22. Name and Address of Facility Bennie Smith Funer 516 S. Main Street nter the mode of dying, such as cardiac	ral Home , Hurloc or respiratory arres	k, Maryland 21643
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Demotina		Interval Batween Onset and Death
,8760,	physician and purial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	nsion		
O. Box 6	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
s, D	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting in the			cco use contribute to the cause of death?
al Recc	iclen: The law r certificate has be rector, page 2 sh	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Record	ding Phys I. After this funeral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ont 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 Residence 28d. Describe how	ce 6 ①Other (Specify) injury occurred
Divis	tel or Attendests after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)	ician: To the best of my knowledge, dea ler: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
/	5 wit 7		29b. Signature and title of certifier		29c. License number	17	Date signed (Month, Day, Year)
	(AA)	ľ	30. Name and address of person who co ANOJ MATHUR, 29449 31. Date filed Will Processor		· ·	1, MD 206	22
	Sta Registra		31. Date filed \$60.5	rogistrat a Grupiature			

Physician Model Beautiful Service and management of the property of the proper				1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of			giene 005	33208
FRANKLIN Y LETZRAR SEPIN 1988 (For continuous, you seemed accompted) 46.13 HARKAN ST. For coal dearent mixed of the property of the coal property of the		Physici	an	1. Decedent's Name (First, Middle, Last)						3. Time of Death
Control Cont									SEPT. 2		M
Second Secretary Number Second Principle Seco	1	Examin	ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of De	ath
206-72-0824 MM 20 F 18 Vs. Months Duty Feb. 16. 1927 Mary land 108-108-108-109-109-109-109-109-109-109-109-109-109					7 40	on //n um lant hirthday)			Doto of Right		
Top State Top Country				216-22-0824		70			(Month, Day		Country)
Second S		land				10c. City, Town or Lo	ocation				10d. Inside City Limits
Second S		Many fehr	ğ	WARNE AND WOMEGOVE	DII	DOGUMENT T. D.					1 ☐ Yes 2 No
Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Salesman Salesman Hardware Company Salesman Sa		r 28a	rec		RY	ROCKVILLE	10f. Zip Code	 		10g. Citizen of What (Country?
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Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Salesman Salesman Hardware Company Salesman Sa		ems	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	fispanic Origin? (S	pecify Yes or No-	14. Race - An	
Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Hardware Company Salesman Salesman Salesman Hardware Company Salesman Sa	936	urs afte al', or It	by		1 (⊠Yes 2 🗆 ! If Yes, Give	No	/		, , , , , , ,		
Second S	Ö	72 ho	ted	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occup	pation	dian	16b. Kind of Busines	s/Industry
18. Mother's Name (First, Mickle, Latel) 18. Mother's Name (First, Mickle, Mickle, Name (First, Mickle, Latel) 18. Mother's Name (First, Mickle, Name (First,	21	thin 7	npie			5+) life.	DO NOT use retire	d) most of wor	King		
Wade Hamilton Leizear Wade Hamilton Leizear Mary Elizabeth Groomes	21	ygien ygien ner th	Con		0	Sale	esman				e Company
20. Maybod of Deposition State 1. Character Charact	land	_ 0 9	o Be		Leizear						nes
20. Maybod of Deposition State 1. Character Charact	ary	shou and N s mar	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbei	r, City or Town, State	Zip Code)
23. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dyring, such as cardials or respiratory strest, immediate Cause (Final Cause) (Final Cau	Σ	and 2 salth a n 27 I		Catherine E. Lei	zear / Wi	Maria Cara		Street,	Rockvill	e, Md. 2	20853
23. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dyring, such as cardials or respiratory strest, immediate Cause (Final Cause) (Final Cau	ore	of He item			Removal from State	20b. Place of Dispo cametery, crai	sition (Name of natory or other pla	сө)	Date	20c. Location - City of	or Town, State
23. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dyring, such as cardials or respiratory strest, immediate Cause (Final Cause) (Final Cau	i m	ment tant:		*4 □ Donation 5 □ Other (Specify))				29/05	Olney, Ma	ryland
Physician (Medical Examiner) Sequentially ist conditions; any, leading to immediate Physician (Medical Examiner) Physician (Bai	permit Depar Impor any In		21. Signature of Funeral Service Licens Thurify	". Bar	les 22	Muriel H	. Barber			20882
Physician (Medical Examiner) The part of				23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each li-	the death. Do not ent					Approximate Interval Between
Sequentially list conditions, any, leading to immediate Cause (Gause (Disease or injury institution). Bequentially list conditions, any, leading to immediate Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury institution)). Begunning the sequence of (Cause (Disease or injury				disease or condition	Ext	earine 1tz	ica Sm	al cell	Lune C		
Sequentially list conditions: Sequentially list conditions:				resulting in death)	Due to (or as	a consequence of):	7				
The part of the pa	н		16	Sequentially list conditions,	b. Due to (or as	a consequence of):					
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a		uted Insit	min	cause Enter Underlying Cause (Disease or injury	2 40 10 (01 40						1
The composition of the composi	ć	execun nanc ial-tra	Exa	that initiated events	Due to (or as	a consequence of):					
FFEMALE: 230. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 Other (specify) 231. Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 3 Date of delivery months and the cause of death? 1 Yes 2 No 2 Date of Date o)9/	ysicia ysicia			d						
9 Unknown 9 Unkn			ledi	ICCCM C							
9 Unknown 9 Unkn	30X	th cer tendir or use	an/N	23b. Was decedent pregnant			Ectopic pregnancy	/			
Spool of the significant conditions continuous continuo	O. E.	ne dea the at hed fo	ysici	1 ☐ Yes 2 ☐ No		t time of death 5	Other (specify)		-	Month	Day Year
The property of the property o	9	that the ed by detac			ntributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
The state of the s	rds,	quires n sign uld be									
The state of the s	000	s bee	ojete								autopsy findings available
The state of the s	Re	9 4 9	E o						perform	ned? death?	
The state of the s	ital	ian: rtifica stor, p	O					26. Place of Dea			5 Z NO
1 Natural 2 Accident 3 Suicide 4 Homicide 4 Ho	>	di di	0		fospital: 1 Inpatie	ent 2 ER/Outpatier	t 3 DOA Oth				ecify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Place of Injury : At home, farm, street, factory, office 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number					28a. Date of Inju- (Month, Da	ry 28b. Time of Injury	Wor	y at k?	28d. Describe ho	ow injury occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32 Registrar's Signature	<u>s</u>	tan leatl lor: the	cat	2 - 7 (00:00:11				Yes 2 □No	201 1 12 12		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32 Registrar's Signature		or Al after of Direction by	ertifi				eet, factory, office				Rural Route Number,
D-0060335 SEPTEMBER 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pan Bonner (Ell Prince Philip Dr # 327 Olner Mp 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	spital ours neral filled		29a, Certifier 1X Certifying Phy	sician: To the best	of my knowledge, death	occurred at the tin	ne, date and place	and due to the ca	ause(s) and manner	s stated
D-0060335 SEPTEMBER 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pan Bonner (Ell Prince Philip Dr # 327 Olner Mp 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ne Ho n 24 h ne Fur netely	dica	(Check only 2 Medical Exami	ner: On the basis of	f examination and/or in	vestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
D-0060335 SEPTEMBER 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pan Bonner (Ell Prince Philip Dr # 327 Olney Mp 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mor	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pan Bonne (Ell Prince Philip Pr # 327 Olney Mp 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature)			Parlka			D-	0060335		SEPTEMBER	26, 2005
Pen Bonnen (811) Prince Philip Dr # 327 Olney Mp 20832		10.		30. Name and address of person who co							
State 31. Date filed (Month, Day, Tear) Supregistrar's Signature			- 1			hilip Pr	# 327	Olney,	MA ZO	832	
Registrar SEP 2 8 2005					35 Hegistra	ars Signature	we	•			

			1 - For State Registrar	State of	Maryland / De		of Health are of Death	nd Mental H	ygien Reg. N	2005	332	0.0
	Dhusis		1. Decedent's Name (First, Middle	Last)		_		2. Date of I			3. Time of	
	Physici /Medi		Edith Marie	Lee				Sept.	25,	2005	5:10	а.м
	Examir	er	4a. Facility Name (If not institution	give street and num	ber)		own, or Location of	Death	40	c. County of Death		
			Potomac Val				kville	I Hen I a D		Montgome		
	Funeral Director		5. Social Security Number	6. Sex 7	Age (In yrs. last birtho	Months		Min. (Month, I	Day, Year) Cou	place (State or ntry)	
	T1		577-07-6482 Usual Residence of Decedent		91 ''			Jan.	31,	1914 Wasl	nington	ı, D.
	yland how		10a. State 10b. County		10c. City, Town of	or Location				1	10d. Inside Cit	y Limits
	e Ma	ctor	Md. Montgo	mery	Rockvi	.11e					1 🏹 Yes	2 □ No
	it the second of 26	Director	10e. Street and Number	•		10f. Zip 0	Code		10g. C	itizen of What Cour	ntry?	
	ath w	rai	1235 Potomac Va				20850			U.S.A		
	er de	Funerai	11. Marital Status	Armed Ford	ent Ever in U.S.	 Was Decede If Yes, specif 	ent of Hispanic Origin by Cuban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	10-	 Race - Americ Black, White, 		
36	F, or	by F	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Dat		1 ☐ Yes 2	No Specify:			Specify: W	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or teme 23a or 28e-f show ant, the Medical Examinsa must be notified at	ted	15. Decedent	s Education	16a. D	ecedent's Usual	Occupation		16b. k	(ind of Business/In	dustry	
215	hin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	grade completed) College (1-4	(0)	Give kind of work fe. DO NOT use	done during most o	f working	100.1	tina or basinosam	adsay	
21	od wit gjene er th	Com	12	Conlege (1-	voi 3+)	Civil	Servant		U.S	S. Federa	1 Gov	t.
nd	al Hy	Be (17. Father's Name (First, Middle, L	ast)			18. Mother's	Name (First, Midd				
yla	Ment Ment arked atic	10	Donatu	s Donaf	riro		Emma	- Fusco				
Maryland	2 sh and is m		19a. Informant's Name/Relationsh		19b. M	failing Address (Street and Number of	or Rural Route Num	ber, City	or Town, State, Zip	Code)	
	1 and 1ealth 9m 27 ther t		Robert Elde:	-cousin	450	O Rivers	side Drive	New Yor				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f show my injury or other treumatic event, the Madical Examines must be notified at anone.		1 Burial 2 Cremation			crematory or oth	er place) Se	ept. 27,		ocation - City or To		
₫	it. Partition		 4 □ Donation 5 □ Other (Sp 21. Signeture of Funeral Service L 		Metropo		rematory	2005	Ale	exandria,	Virgi	nia
Ba	perm Depa Impo any i		1 10	X - 4			Address of Facility					
			23a. Part1. Enter the disease, or o	complications that car	used the death. Do not		sconsin A			ington, l	Approximate	
	Dhusisian		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final				o. a)g, ocor, ao ca	, and or respiratory	arrost,		Interval Betwee	een
	Physician / /Medical		disease or condition resulting in death)		ration Pnet							
8	Examiner				ricular Fil		On					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequence of):		.011				-	
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	с								
, 0,	oe exe cian a rurial-	Ě	resulting in death) Last	Due to (or	as a consequence of):							
8760,	cate be executed physician and the burial-transit	dicai		d								
9		/Me	IF FEMALE:	23c If yes outer	me of pregnancy							
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt		3 Ectopic preg			1	23d. Date of delive Month	ry Day Ye	ar
o.	y the	iysic	1 Yes 2 No 9 Unknown	9 Unknow		J □ Other (spec	:iiy)					
<u> </u>	The law requires that the the has been signed by the bage 2 should be detached.	by Pr	Part II. Other significant condition	s contributing to dea	th but not resulting in th	e underlying cau	ise given in Part I.	23e. Did	tobacco t	use contribute to th	e cause of dea	ath?
Records,	n sign							1 🗆	Yes 2	X No 3 ☐ Prob	ably 4 □Un	known
000	s been s	olete						24a. Wa	s an	24b. Were autor	osy findings av	
Re	The lav	Completed						auto	opsy ormed?	24b. Were autor prior to con death?		ise of
ta		BeC	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only	2∏No	1 🗆 Yes	2 No	
>	S S	TOE	examiner? 1 ☐ Yes 2 🛂 No -	Hospital: 1 ☐ Inp	atient 2 ER/Outpa	atient 3□ DOA	0.1	ng Home 5 ☐ Res		6 ☐Other (Specify	')	
0	- ro		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Tim Day Year) Injur	e of 28c	: Injury at Work?	28d. Describe			,	
SIO	endin eath. or: Ai	catic	2 ☐ Accident investiga	ition		М	1 Yes 2 No					
Division of Vital	or Attendation of Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of	Injury - At home, farm, , etc. <i>(Specify)</i>	street, factory, o	office	28f. Location City or To	(Street an wn, State	d Number or Rurai	Route Numbe	3r.
	To the Hospitet or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the funer		On Conting AM Co. 11	Observation of				-				
	Hosi 24 ho Fune fely f	edicai	29a. Certifier 1 \(\infty\) Certifying (Check only one) 2 \(\infty\) Medical E	kaillitier: On the basi	est of my knowledge, design of examination and/o	eath occurred at r investigation, in	the time, date and p my opinion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of cellufier	and manner	stated.		icense number	-		te signed (Month, L		
	F 3 F 8			1 //							,	
	5	-	30. Name and address of person w	no completed cales	Marth (Itam 222) T		0051280		Sep	t. 26, 20	005	
				adgar, M.	1		Center Dr	ive, Rock	vill	e. Md. 20	0850	
	Sta	е	31. Date filed (Month, Day, Year)					, 1001		-, =(
	Registra	ar	SEP 29	2005	istrar's Signature	TO SALL						

			1 - For State Registrar	State of M	1 arylan		artment of H		d Mental Hy	/giene	711115	33211	0
	∍ Physici	an	Decedent's Name (First, Middle, La	rst)		\ .			2. Date of Do Month	eath Da	ıy Yea		
	/Medi	cal	Donald 4a. Facility Name (If not institution, given	o atract and sumbar	-1	La	WS	1	Septem		28 200		M
*	Examir	ner	Johns Hopkins				4b. City, Town, or Baltimo			40	c. County of De	eath	
	Funeral					ast birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of Bi	rth	9. E	Birthplace (State or Foreig	an
	Director		222-40-3251	1 ∑ M 2□F	53	Yrs.	Months Days	Hours M	lin. (Month, Di	ay, Year, 1952	DE	Country) LAWARE	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limit	•
	Maryl f sho	20	Delaware New C	astle		wnser						1 Yes 2 34N	
	r 28e	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What	Country?	_
	ours after death with the Marylan el', or Items 23a or 28e-f show Exercities and be notified at	al D	281 Oliver Gue	ssford R	≀d.		1973	4		USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n. Mexican. Pu	(Specify Yes or No	0-	14. Race - Ar Black, Wi	merican Indian,	
36	rs afte	by Fu	1 ☐ Never Married 2∑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 S If Yes, Give Year or Dates:	_	1	_	Specify:	, ,		Specify: W		
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show areal Examiner , ust be multified at	edt	15. Decedent's E		·	16a, Dece	ient's Usual Occupa	ntion		16b K	(ind of Busines	ss/Industry	
215	C * 5	plet	(Specify only highest gri	ade completed) College (1-4or	5+)	(Give life.	kind of work done d DO NOT use retired,	furing most of v	working	100.11	and or Eddino.	Samuel y	
2	filed withii Hygiene. other then ent, the M	Completed	12		.,	Owne	r;Heati	ng Oil	L Co.	Oil	Co.		
Maryland	Ø @ ₩ ≥	Be	17. Father's Name (First, Middle, Last Charles R. La	•				18. Mother's N	lame <i>(First, Middle</i> n Milla		Sumame)		
Z	2 should be f and Mental P le marked of aumatic eve	10	19a. Informant's Name/Relationship			10h Mailie	a Address (Chron				T 01 1	7.0.1	
	es 1 and 2 should to of Health and Ment fitem 27 le marked ir other traumatic e		Eleanor Laws-				g Address (Street a					, <i>zıp Code)</i> d , DE . 1973 (4
Ē,	item item other	1	20a. Method of Disposition			ace of Disno	sition (Name of natory or other place		Date Na.		ocation - City		-
Ē	Pages nent of I ant: If its ary or o	H	1 ☐ Burial 2 【※Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		9		. Cremat		-29-05	Do	ver,	DE.	
Baltimore,	pernit. Pag Department Important: I any njury o		21. Signature of Funeral Service Nice	nsee	1	D 7	Name and Addres	s of Facility	ITSON				
=	205 29		Raul Hit	Chison	1	21	2 N. Br	oad St	MIddl	eto	wn, DE		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death	. Do not ent	er the mode of dying	, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	rrysician /Medical	Ĥ I	Immediate Cause (Final disease or condition resulting in death)	a	h'sys		Organ	Failur	re			3 days	
	Examiner		1	Due to (or as		ence of): Hear	t Failur	φ.				4 days	
		Jer	Sequentially list conditions, if any leading to immediate	b. Due to for as	a conseque	ence offic	From					4 days	
1,5	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			lung		lant				4 days	
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequ							16 year	4
87	ate hy the	dica		_ d		0 51 5					_	regette	7
9 x c	death certifics e attending pl d for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnar	ncy					22d Data of d	aline se	
Вох	death s atter d for u	iclar	in the past 12 months?	1□Live birth 4□Pregnant a	2 Fetal	death 3□	Ectopic pregnancy Other (specify)			1	23d. Date of d Month	Day Year	
	t the by th ache	hys	9 Unknown	9□ Unknown									
Ś	ng De	by	Part II. Other significant conditions	contributing to death t	but not resul	lting in the ur	iderlying cause give	n in Part I.				to the cause of death?	
oro	requi	eted							- 10	Yes 2	□No 3□F	Probably 4 Unknown	n
Vital Record	e lay has ye 2	Completed							24a. Was			autopsy findings available completion of cause of	
la	ician: The certificate ha ector, page	e Co	25. Was case referred to medical						1 ☐ Yes	28 No	1 Ye		
5	Physician: this certific al director,	To Be	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital:	ent 2∏F	R/Outpatien	Othor		eath Check onl o		6 MOther (Se	onife!	
			27. Manner of Death	28a. Date of Inju	ury	28b. Time of Injury	28c. Injury Work		28d. Describe			вспу)	-
Siol	Attending r death. sctor: After by the fune	catlc	2 Accident investigation	n	, ,	,,		es 2 □No					
É	for Attenated after deat Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hor tc. <i>(Specify)</i>	me, farm, stre	et, factory, office		28f. Location (S City or Tov			Rural Route Number,	
_	Hospitel 24 hours a Funerel C		29a. Certifier + Certifying Ph	ysician: To the best	of my know	dedne death	occurred at the time	date and pla	ce, and due to the	221122(2)	and manage	an etated	
	- (4 - 17	edical	(Check only 2 Medical Exar	niner: On the basis of and manner st	of examination	on and/or inv	estigation, in my opi	nion, death oc	curred at the time,	date and	anu manner a I place, and du	e to the cause(s)	
	To the within 2 To the Comple(Me	29b. Signature and title of certifier				29c. License	number		29d. Dat	te signed (Mor	nth, Day, Year)	
	0		Melen	(deny	2		RES-	000		Seph	ember	28,2005	
	1		30. Name and address of person who				•						
	Sta	to	Melissa Camp 31. Date filed (Manuer Bay, Year)		V . w			Himon	e MD	a	1287		_
ni.	Registr		31. Date filed (MoSIEPy, 3°ar) 2	005 32 Hegisti	~ 1	Tre of	where						

CPM 05-06764 Barbara Lyo

a Lyons	•	1 - State Unpend Item 2 RegistrarAmend Item 2	State o 3a,27,2 27 per	Marylar 8a-1 po me G849	er me (idine tifica	te of l	ealth a Death	and M tas 11-10	lental)-05	Hygiota tas	ene g. No.	-0-5	
Physiciar /Medica	_	1. Decedent's Name (First, Middle, Last Barbara Ann	•							Mont	of Death th ober	Day	U.5 005	3. fine of beath 20:18
Examine		4a. Fecility Neme (If not institution, give 23 Pier Side Driv			02		, Town, or Balti		of Death			4c. County	of Death	
Funeral Director		5. Social Security Number 6. Se 177–34–4178		7. Age (In yrs. 62			er 1 Year	If Under Hours	Min.	8. Date (Mon Feb	of Birth th, Day,	^{Year)} 1943	Cour	olace (State or Foreig oftry) York
yland	-	Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside City Limit
r 28a-f ehow	Director	Maryland						ltim	ore					1 ½ Yes 2 □ N
death with the Maryland ms 23a or 28a-f ehow fraust be notified at	2	10e. Street and Number 23 Pier Side Dri	ve, Apt	. 402		10f. Z	ip Code	212	30		10	g. Citizen of \ U	What Cour SA	ntry?
or ite	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv	edent Ever in Urces? 2 🔯 No		Was Decilif Yes, sp	edent of Hi ecify Cuba 212 No	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	cify Yes Rican, et	or No-		ck, White,	ean Indian, etc. white
"natural",	ed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Year or D	ates:	16a. Dece	dent's Us	ual Occupa	ition			10	6b. Kind of Bu		
	Completed	(Specify only highest grade Elementary/Secondary (0-12)		-4or 5+)	(Give	kind of w DO NOT	ork done d use retired make:	luring mos)	t of worki	ng			n Hom	
d oti	To Be C	17. Father's Name (First, Middle, Last) David Finger									Middle, Ma steir	aiden Suman	70)	
od 2 shouth and N		19a. Informant's Name/Relationship (T) Benjamin M. Lyons										City or Town, MD 2		Code)
ages 1 and 2 nt of Health a : If item 27 I or other tra	Ì	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ I	Removal from	State	Place of Dispo cemetery, crer	esition (Na matory or	ame of other plac	9)	D	ate	20	0c. Location -	City or To	
permit. Pages Department of Important: If i eny injury or once.	1	4 Donation 5 Other (Specify,		M20723	arroll	2. Name a	and Addres	s of Facilit		Eline	e Fur	Hamps neral H	Home	
403 • 4	+	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that c	aused the dea	th. Do not ent							ead, MI) STO	Approximate Interval Between
flicate be physicials to the bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consec										
that the death certific ed by the attending p detached for use as	Pnysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregninth 2 Teta ant at time of common	aldeath 3□	Ectopic Other (s	oregnancy specify)					23d. Dat	te of delive nth	ory Day Year
es i	_ ⊆	Part II. Other significant conditions co	ntributing to de	eath but not res	sulting in the u	nderlying	cause give	n in Part I.		23e.		acco use cont		ne cause of death? ably 4 □Unknow
hes b	Completed										Was an autopsy performe	ed?	Were auto prior to con death?	psy findings availal apletion of cause of
cian ertifi ector,	e a	25. Was case referred to medical examiner?	Hospital:				OA Othe	26. Place						COLLEGE
er this eral di	0	27. Manner of Death	28a. Date o	of Injury	28b. Time of		OA Injury Work	4 🗀 190			Residen	v injury occurr) SCENE
Attending Profession of the funeral py the funeral states of the f	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide determined	-	of Injury - At h	8:10 ^y found	\mathbf{p}^{M}	1 🗆 '	es 2 🗶		-		ingest		ugs Route Number, Side Driv
		4 [] nomicide	resid	lence					A	pt.40	02 Ba	altimo	re, M	aryland
Hosp 24 hou Fune etely fi	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ner: On the ba	best of my kno asis of examina per stated.	owledge, deatl ation and/or in	occurre vestigatio	d at the tim	e, date an inion, dea	d place, a th occurre	and due t ed at the	o the cau time, dat	use(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
To the within To the compl	Re	29b. Signature and title of certifier	Deo	el r	()	29	c. License	number	.E.			d. Date signed		
0		30. Name and address of person who co			m 23a) (Type,	Print) Penn	Stree	et, B	alti	nore	, Mai	ryland	2120	1
State	е	31. Date filed (Month, Day, Year) OCT 0 7	32. R	strar's Sign	ature	_								

			1 = For State Registrar	State of Maryla		artment of I			ene .Q.N.N.S	22212	
· 36	2/2	- ja	Decedent's Name (First, Middle, La	st)				2. Date of Death	6000	3. Time of Death	
	Physici /Medio Examir	al	Daniel Morgan 4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Deat	September 1	Day Year 25, 2005 4c. County of Dea	7:15 P M	
-44			Shady Grove Adve		1 s. iast birthday	Rockvill		8. Date of Birth	Montgomer	y thplace (State or Foreign	
	Funeral Director			₩ 2□F 47	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)		Germany	
	anyland show	_	10a. State 10b. County	10c. C	lity, Town or L	ocation			·	10d. Inside City Limits	
	in 72 hours after death with the Maryland "anatural", or items 23a or 28a-f show isoloal Examinating the motified at	Director	Maryland Montgomen	y Ga	ithers	burg 101. Zip Code		10	g. Citizen of What C	11 Yes 2 No ountry?	
	h wit	O E	431 Christopher A	venue #24		20879		I	JSA		
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub			14. Race - Ame		
36	s after , or ite	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 20XNo		to Alcan, etc.)	Specify: W1	nite	
2-00	72 hour		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	rking 10	5b. Kind of Business		
Maryland 21215-0036	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire very Dri	nd)		Automotiv	e	
	Hyg Hyg ent,	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, Ma	aiden Sumame)		
	should be nd Mental marked o	1 1	Jerry Morgan				Eva Ja	kutsch			
Jar	2 g m m		19a. Informant's Name/Relationship (ural Route Number, (-		
	C = 04 F		Jerry Morg.					#24,Gaith	ersbur M		
nor	0 0		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			osition (Name of matory or other pla		/30/2005 E			
Baltimore,	# 8 8 F 4		21 Signature of Fundral Service Licer	- 1	2	2 Name and Addre	ess of Facility				
ã	Den gang) July 1	my little	S:	imple Tri NAO Rockv	bute Fundille Pik	eral and (e Rockvill	Cremation Le MD 2085	Center	
Ģ.	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the decone cause on each line.						Approximate Interval Between	
I K			Immediate Cause (Final disease or condition resulting in death)	a anoxic		Onset and Death days					
	Examiner		- 1	Due to (or as a consequence of): Cardiac arrest days							
	p #	ner	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse							
P.O. Box 68760,	ate be executed hysicien and the burial-transit	licai Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Atheroso		ic Coro	nary a	rtery d	i'sease	years	
	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tat death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year	
	uires that signed b	þ	Part II. Other significant conditions of	ontributing to death but not re	-	inderlying cause giv	ven in Part I.		4	o the cause of death?	
Records,	e law requir has been si je 2 should I	Completed	diabetes	mellitus 24a. W					24b. Were a	utopsy findings available completion of cause of	
<u>~</u>		Сош						performe			
Zita Zita	ysician: 1 is certifical director, p	Be	25. Was case referred to medical examiner?	Hospitals d		1 04		ath (Check only one)			
of	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: Impatient 2	1	III JUDON		lome 5 Residen		cify)	
ion	ing After uner	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo	ryat rk?]Yes 2 □No	28d. Describe how	rinjury occurred		
Division of Vital	7 0 2 2	Certification;	3 Suicide 6 Could not b 4 Homicide determined						t and Number or Rural Route Number, tate)		
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the travestigation, in my	red at the time, date and place, and due to the cause(s) and manner as stated. tion, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
	To th To th compl	Me	29b. Signature and title of certifier			29c. Licens	se number		d. Date signed (Mont		
)	5		> Flicia ,		ND		1738			ber 26,2005	
			30. Name and address of person who Alicia T. Mist	completed cause of death (tte	em 23a) (Type, edical	Print) Conter	Drive	Rockvi	ile, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2 8	32. Rägistrar's Sign	nature	partes					

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of rtificate o				giene 0 ()5	33213	3
1. Decedent's Name (First, Middle, Last)									2. Date of De		Year	3. Time of Death	_
	Physici /Medio		Mariam Pauline Myers						Sept	24 200		6:00 a	М
	Examin		4a. Facility Name (If not institution, give			4b. City, Town				4c. County			
			411 Kate Wagner			Wes	tminst			Ca	errol		
	Funeral Director		5. Social Security Number 6. S 217-24-3563 Usual Residence of Decedent	ex / Age □ M 2⊠F	(In yrs. last birthday) 77 Yrs.	Months Day		Min.	8. Date of Bird (Month, Da June 0	th y, Year) 4 1928	9. Birthp Cour	place (State or Foreigntry) MD	gn
	ow it		10a. State 10b. County		10c. City, Town or Lo	cation					1	Od. Inside City Limit	ts
	the Marylar 28e-f show notified st	ठ्	MD Carro	o11	Westm	inster						1 ☐ Yes 2 🛛 N	0
	or 28c	lrec	10e. Street and Number			10f. Zip Code)			10g. Citizen of V	√hat Cour	ntry?	
	23a c	alD	411 Kate Wagner	Road		21	157			USA			
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other then "neturel", or Items 23a or 28e-1 show or other treumatic event, Ite Mudical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo	Was Decedent of Yes, specify Co			ecify Yes or No Rican, etc.)	- 14. Race Blace Specify	k, White,	ean Indian, etc. ite	
	ithin 72 ho ne. nen "netur neutical i	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)							16b. Kind of Business/Industry			
	filed w Hygier other th		11		H	omemake			/First Adjusted	Own H			
Maryland	2 should be filed within and Mental Hygiene. is marked other then eumatic event, the Mental Men	То Ве	17. Father's Name (First, Middle, Last) Monroe Burns Dell						ice Tro	Maiden Sumam Ott	9)		
an	and l		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mailir	ng Address (Stre	et and Numb	er or Rura	l Route Numbe	er, City or Town,	State, Zip	Code)	
	1 and 2 Health tam 27		Roger J. Myers/h	ısband		Kate Wa	mer R			nster, M		1157	
Baltimore,	ges 1 if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crer	natory or other p			ate	20c. Location -	•		
Ë	t. Pa rtmen rtent: njury		'4 □Donation 5 □ Other (Specify		Sandy Mo	unt Ceme	erv.	9/27/		Finksbu			
Ba	permit. Pages 1 an Department of Heal Importent: if itam 2 any injury or other once.		21. Signature of Funeral Service Licen	500	# # 4	ritts fi 12 Wash:	ineral ington	"Home Road	and Ch Westr	napel, P minster,	.A. MD	21157	
Г	Frrysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between										
		disease or condition								Onset and Death Syears			
			resulting in death)	Due to (or as a	a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						,	
		ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a									
8760,	icate be executed physicien and s the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.											
687	ificate g phys	edlo	-	d									
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown 9 □ Unknown									23d. Date of delivery Month Day Year	
Δ.	res that the de igned by the a be detached f	/Ph	Part II. Other significant conditions of	ntributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?				
ords,	w requires been sign should be	ted by	HYPERTO	USION					1 🗆 Y	es 2XNo	3 🗌 Prob	ably 4 ⊟Unknown	n
Record	The law rate has be page 2 sh	Completed								med? d	rior to cor eath?	psy findings available projection of cause of 2 No	Θ
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	I I i - i				e of Death	(Check only of	ne)			
) (Physician: r this certificanal director,	2	1 1 195	Hospital:		I SU DOA		ursing Hon	- 1			"	_
uc	ting f	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?								a			
Division of Vital	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				M 1 ☐ Yes 2 ☐ No eet, factory, office			28f. Location (Street and Number or Rura City or Town, State)		l Route Number,	-
	Hospitel 4 hours a Funerei i ely filled	Medical Co	29a. Certifier Check only one) Certifying Physical Example 2 Medical Example 2 Medic	iner: On the basis of	f my knowledge, death examination and/or inv	occurred at the restigation, in my	time, date an	nd place, a	and due to the o	cause(s) and mar	ner as st	ated. the cause(s)	
	To the h within 2 To the f complete	Mec	29b. Signature and title of certifier	and manner state	ENDING	29c. Lice	nse number			29d. Date signed	(Month, I	Day, Year)	
	M32		SCHI	/ ' ' '	"HYSICIAN		2115	55		0	~ /	2005	
	44		30. Name and address of person who of ALTHUL L. EUD			Print)	KD	WES	72 W 27	ree MI	-	1157	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7	32. Registra	r's Signature	had.				,			

			1 - For State Registrar	State of	Maryland / De	partment of				2005	33216		
	Physici	an	Decedent's Name (First, Middle, La Uolon, M.	•						2. Date of Death Month Day Year 3. Time of Death			
	/Medio		Helen M. Moore 4a. Facility Name (If not institution, give street and number)				wn, or Location of		otember 23, 2005 5:32 P M				
1	Lxaiiiii	iei	1916 Marconi Circ		,	Annapo		or Bount	Anne Arundel				
	Funeral		5. Social Security Number 6. S	ех 7.	Age (In yrs. last birthd	ay) If Under 1 Y					place (State or Foreign		
	Director		210-30-0109	□ M ¾ (X)F	84 Yrs	. World's D	ays Hours	9-8-1	921	Cana			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	r Location					0d. Inside City Limits		
	Maryl f sho	ō	Maryland Anne Ar	I obau							1 ☐ Yes 2 ☑ No		
	r 28a	Director	10e. Street and Number	uncer	AIII	apolis 101. Zip Co	de		10g. Ci	itizen of What Cour			
	7 with		1916 Marconi Cir	rcle		21	401		US	Δ			
	ems ems	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 1			gin? (Specify Yes or i		14. Race - Americ			
99	or it		1 Never Married 2 Married	1 Tes 2	IX No	1 ☐ Yes 2 🔀		i, r dello riicali, etc.)		Black, White, Specify: Wh	ite		
Ö	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show ita Medical Examinar must be notified at	ed by	3 X Widowed 4 □ Divorced	Year or Date					1 101				
7.	n "na	plete	15. Decedent's Ed (Specify only highest gra	de completed)	(G	ecedent's Usual Or ive kind of work di e. DO NOT use re	one during most	t of working	16b. F	Kind of Business/In	dustry		
212	e filed within al Hygiene. other than vent, the Me	Completed	Elementary/Secondary (0-12)	1 year	or 5+)	Homemake	er			Home			
p	be filed within 72 hours after death with the Marylan it all tyyliene. It other than "natural", or filems 23a or 28a-f show other than "natural", or filems 23a or 28a-f show avent, I'm Medical Evaminat must be notified at	Bec	17. Father's Name (First, Middle, Last)					r's Name (First, Midd					
Maryland 21215-0036	2 should be and Mental is marked sumatic ev	2	Martin M			Ellen Gall	aghe	r					
Nar	s 1 and 2 should f Health and Men item 27 is marke other traumatic	1.0	19a. Informant's Name/Relationship (r or Rural Route Num	-	000000	Code)		
a)	s 1 and 2 of Health a item 27 is other tra		Martha E. Anderso	n/ Daugh		50 Brisco	oe Turn	Rd., Owin	gs, 1	ID 20736 ocation - City or To	State		
<u>5</u>	Pages nent of I int: If it		1X Burial 2 ☐ Cremation 3 ☐		210	sposition (Name or crematory or other			1				
Baltimore,	+ # # · ·	li	 4 ☐ Donation 5 ☐ Other (Specify 21. Sign ware of Funeral Service Up of 		MD vece	rans Ceme		9-27-05 ^y George P		ownsville			
ä	Depa Impo any ir	t ia	Multillan			2973 So	lomons 1	Island Rd.	• Na.	water. M	ат ноше D 21037		
			2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
	Physician and bursician and street pe executed bursician and street principle.		Immediate Cause (Final disease or condition WEASTATIC BREAST CANZER SYFA										
			resulting in death)	as a consequence of):		3 (0.11)							
		_	Sequentially list conditions,	b. — Physical Rev Rose	as a consequence of)								
		nine	Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury										
–		Examiner	that initiated events resulting in death) Last	c Due to (or	Due to (or as a consequence of):								
8760,		dicall		d									
99	ntifica ng ph as th	Aedi	IC CCUM C	-									
Вох	eath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth		3 Ectopic pregna	ancv			23d. Date of delivery			
0.	the at	Physiclan/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnan 9□Unknow	t at time of death	5 Other (specify				Month	Day Year		
٥.	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Ph.	Part II. Other significant conditions of	ontributing to deat	h but not resulting in the	underlying cause	a given in Part I	23a Dio	Ltobaccou	use contribute to th	a cause of death?		
Records,	uires tha signed Id be de	d by		g.		and onlying dadoc	giron in rairi.		,	No 3 Prob			
50	pluods	lete						24a. Wa					
Re	The lav	Completed							autopsy prior to completion of cause performed?		npletion of cause of		
		BeC	25. Was case referred to medical				26. Place	of Death (Check only	2 No	1 □ Yes	2 No		
	d is	To B	examiner? 1 🗆 Yes 2 X No	Hospital: 1 ☐ Inp	atient 2 ER/Outpat	ient 3 DOA	Other			6 ☐Other (Specify)		
0	ng Pt Ifter th		27. Manner of Death 11. Natural 5 Pending	28a. Date of I (Month,	njury 28b. Time Day Year) Injury	e of 28c. I	njury at Work?	28d. Describe	how inju	ry occurred			
Sio.	Attending Physician: r death. sctor: After this certifica by the funeral director.	catl	2 Accident investigation 3 Suicide 6 Could not be										
É	i Diri	Certification:	4 Homicide determined	289. Place of	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier Certifying Ph	/sician: To the be	st of my knowledge, de	ath occurred at th	e time date and	place, and due to the	a cause/s)	and manner as at	ated		
	n 24 h n 24 h ne Fui	Medical	(Check only 2 Medical Examone)	iner: On the basis and manner	s of examination and/or	investigation, in n	ny opinion, deat	h occurred at the time	, date and	d place, and due to	the cause(s)		
	vithii To th	Ž	29b. Signature and little of certifier	, ILIA		29c. Lic	ense number		29d. Dai	te signed (Month, L	Day, Year)		
			Mexen/1000	(IMI)			16364	7	91	24105			
			30 Name and address of person who	ompleted pause of	death (Item 23a) Typ	e. Print)	NADA	110 20	KL				
	Sta	to.	31. Date filed (Month Day Year)	32. Re	strar's Signature	200 W	(NITILL)	7 WII CI	101				
	Registr			2005		Shools							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Van **Physician** 9:30 P M September 22, BEATRICE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Nov. 8, 1932 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗡 F 577-46-5076 72 Pennsylvania Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Frederick Keymar Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11869 Renner Rd. 21757 death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Katherine Cook James Eisenman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11869 Renner Rd. Keymar, MD 21757 James D. Mohr/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Hill Cemetery 9/26/2005 nr. Woodsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fureral Service License amarine 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocandial In landson Physician Acrte /Medical Due to (or as a consequence of) Examiner CAP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician ra ms Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA his After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 2 Accident 5 Pending 1 TYes 2 TNo within 24 hours after death. To the Funersi Director: A investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46248 9/24/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARtha Three, MO 300 W. 9th St. Frederick, MD 21701 32. Registar's Signature 31. Date filed (Month, Day, Year) State Bleeve & Spark Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Frances JoAnne Morrison September 27,2005 8:23 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Prince George's Hospital Center Prince George's Funeral 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ F 63 Director 253-68-0819 8/7/42 Columbus, Ga. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or items 23s or 28s-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at Md. P.G. Landover Director M Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 928 Portia Court 20785 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 287 Married Baltimore, Maryland 21215-0036 Specify: African-1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Nursing 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hadley Alice Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other trac Herman R. Morrison/Husband 928Portia Ct., Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State iX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem, 10/3/05 Cheltenham, Md. 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee any 1 all 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC **Physician** FATKL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 🛣 No the ρ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DIKBETES 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? this certificate ASTHMA Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending thin 24 hours after death.

the Funeral Diractor: A mpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAKRY CHEVERLY MD 20185 3001 HOSPITAL LITTLE 31. Date filed (Month, Day, Year) SEP 3 0 2005 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygien 200533217 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** September Martin 28, 2005 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges's General Hospital ${ t Cheverlv}$ Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2XX Director 578-30-8361 November 2,1927 Washington, DO Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28a-1 show other treumatic event, I've Medical Exacting Count be notified at 1 X Yes 2 □ No Director D.C. Washington, DC 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3721 South Dakota Avenue, NE 20018 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Wesley Moore Eva Breeden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other tree QDGs. George M. Martin - Son 742 Skyview Drive, Lusby, MD 20657 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery October 1.2005 Suitland. M. 22. Name and Address of Facility
George P. Kalas Funeral Home.
6160 Oxon Hill Rd., Oxon Hill 21. Signat of Funeral Service Licensee 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of) Examiner Cerebral Anoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit certificate be executed c. Chronic Obstructive Pulmonary Disease that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown s been sign Aortic Stenosis Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X X** 0 1XXnpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a 29a. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie, 29c. License numbe 29d. Date signed (Month, Day, Year) 3 MD 21688 09/30/2005 Muame M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3300 Pennsylvania Ave., SE Washington, DC 20020 Edwin Williams, M.D. 32. Registrar's Signature Registrar

			For State Registrar	State of I	Viarylan		artment of rtificate of		and Mental H	ygiene Reg. No.	2005	33218
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E - 4	Director		Usual Residence of Decedent	TOTAL TOTAL		Yrs.			Sept. 2	2, 194	44 Nor	th CArolina
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036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Macilian Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 💆 Divorced	12. Was Decede Armed Force of 1 TYPes 2 [If Yes, Give Year or Date	ss? □ No 19	62	Was Decedent of if Yes, specify Cul 1 ☐ Yes 2 ☑ No	ban, Mexica	igin? (Specify Yes or I n, Puerto Rican, etc.)		4. Race - Amer Black, White Specify: B	
Maryland 21215-0036	nin 72 ho In "natul Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		25 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of working		d of Business/I	ndustry
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Mary	1 and 2 sho Health and ! Iem 27 Ie ma		19a. Informant's Name/Relationshi Lucille Murphy			19b. Mailin 4303	ng Address <i>(Str</i> ee Canyonvi	ew Dr	er or Rural Route Num ive Upper	nber, City or Marlbo	Town, State, Z	^{iip Code}) 772
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.			amatani ara	esition (Name of matory or other pla emorial	Park	Sept. 30,		ation - City or T Suitlar	
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	/Medical Examiner		resulting in death)	Due to (or	as a conseq		11-01-0					
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<u>≥</u>	of or Attendated attended the Director:	Certification:	4 Homicide determin		etc. (Specif		eer, factory, office	,		Town, State)	realizer or 71g.	rai rioute ivamber,
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	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City	, Town, or Lo	cation of Death			ounty of Death	
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other treumatic event, the Marchal Examiner. The notified at ODGs.		19a. Informant's Name/Relationship (Ty	· · · · · · · · · · · · · · · · · · ·		-			ral Route Numbe		Town, State, Zi 0735	p Code)
2	and ealth m 27		Gregory P. Mill		20b. Place of Disp		•		inton, I		ation - City or 1	own State
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Si		cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, s				28f. Location (Street and	Number or Ru	ral Route Number,
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_	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	in in	29a. Certifier 1 CCertifying Phy	sician: To the best of n	ny knowledge, de	ath occurre	ed at the time,	, date and place	, and due to the	cause(s) a	and manner as	stated.
	24 h 24 h Fur	ledical	(Check only 2 Madical Exam	iner: On the basis of ex and manner stated		investigati	on, in my opir	nion, death occu	irred at the time,	date and p	place, and due	to the cause(s)
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0	(2)		30. Name and address of person who d	ompletar stuse of deat	th (Item 23a) (Typ	e, Print)				77-1-82		
1			Maria Ta	ayag, M.D.	1500 Fo	rest	Glen F	Road, Si	lver Sp	ring,	MD 2	0910
108	St Regist	ate	31. Date filed (Month, Day, Year) CFD 2 9 2005	2. Registrar's	Signature	de						

			1 - State of Marylan	-	artment of Health and lartificate of Death		ene g. N2 0 0 !	5 33220
	Physici /Medic		1. Decedent's Name (First, Middle, Last) KATIE MASSENAERG			2. Date of Death Month Sept. 26	Day Ye	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	h	4c. County of D	
			Prince George Hospital 5. Social Security Number 6. Sex 7. Age (In yrs.	last hirthday)	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince	
	Funeral Director		100-30-6005 Usual Residence of Decedent	Yrs.	Months Days Hours Min.	Aug. 22,		Birthplace (State or Foreign Country) Couth Carolina
	yend Mo			ty, Town or Lo	cation			10d. Inside City Limits
	Man Ba-f sh	tor	Maryland Prince George	Seat	Pleasant			11∑Yes 2 ☐ No
	or 28	Olre	10e. Street and Number		10f. Zip Code		g. Citizen of What	
	eth w	ral	7005 Valley Park Rd.		20743		nited St	
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic avent. The Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Vas Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. Black
Ö-	72 hol	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	rking 16	5b. Kind of Busine	ess/Industry
2	ithin Te.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of wor DO NOT use retired)			2
7	e filed within al Hygiene. other then '		12th 17. Father's Name (First, Middle, Last)	Custo	dian Engineer	ne (First, Middle, Ma		Government
Maryland	ld be f ental F ked of	To Be	Willie Spann			McFadden		
ary	2 should be and Mental la marked (reumatic av	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Ru	ıral Route Number, (City or Town, Stat	e, Zip Code)
Σ	is 1 and 2 of Health a litam 27 la other tree		Joseph Massenberg, Jr.		Lakehurst Ave; Fo	orestville	e, MD. 2	20747
ore	ges 1 t of Hi If itar		1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, crer	sition (Name of matory or other place)		oc. Location - City	
altimore,	t. Pag rtment rtant:		`4 □Donation 5 □Other (Specify) Li			. 30, 200.		land, MD.
Bal	permit, Pages 1 Department of F Important: If its any injury or ot once.		21. Signature of Funeral Service Licensee	4	2. Name and Address of Facility F 5 F	ope Funer 538 Marlb orestvill	oro Pike e, MD.	20747
F			23a. Part I. Enter the disease, or complications that eaused the deat shock, or heart failure. List only one cause on each line.	h. b o not ent	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	RDIAC	ARRHYTHMIA			Onset and Death
	/Medical Examiner		Due to (or as a conseq	uence of):	ARRHYTHANIA RT FAILURE			
		er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying		PAILAKE			
	cuted nd ransit	Examine	that initiated events					
o,	e exec len ar urial-tu		resulting in death) Last Due to (or as a conseq	uence of):				
68760,	ficate be executed physicien and is the burial-transit	edical	d. HYPERTENSION					
Box	sath certii attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 23c. If yes, outcome of pregnate 1 □ Live birth 2 □ Feta	death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
P.O.	t the by the tacher	hys	9 □ Unknown					
	w requires that the deben signed by the should be detached	Completed by P	Part II, Other significant conditions contributing to death but not res RENAL INSUFFICIENCY COLON	CAN	CER,			e to the cause of death? Probably 4 Unknown
eco	e taw re has bev je 2 sho	plet	DEEP VEIN THROMBUS HISTORY, C	HRONIC	LYMPHOCYTIC	24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Ě	The ate h page	Corr		MENI	GENIA	performe 1 ☐ Yes 2 2	death	?
/ita	Phyeiclan: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?		0.1	th (Check only one)		
of	Physic this ral dir	2:	1 ☐ Yes 2 🕱 No 1 1 ☐ Inpatient 2 🗷 27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of		ome 5 Residence		(pecify)
on	ding h. After fune	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe now	inquiry occurred	
Division of Vital Records,	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specif.)		eet, factory, office	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	e Hospital 124 hours a la Funaral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knot one one of the properties of the propert	wledge, death	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau irred at the time, date	se(s) and manner and place, and c	as stated. due to the cause(s)
	To the within 2 to the Complete	Me	29b. Signature and title of certifier	Λ	29c. License number		I. Date signed (Mo	* '
}	0		> Soulds He	2 .M	1 140390		9-28	-05
	U		30. Name and address of person who completed cause of death (Item DR SARAS WATHY RAMA CHANDRAN	1 23a) (Type,	Print) 1 MERCANTILE LAN	E LA	RGO, MD	20174
	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signa	iture	1.		,	

-0 .G	440		1 - For State Registrar	State of M	Marylan		artment of H		and Mental H	ygiene Reg. Ne	2005	33221
	Physicia	an	Decedent's Name (First, Middle, L						2. Date of D Month Septe	Death Da	you Xear	3. Time of Death
	/Medic	al	Steven 4a. Facility Name (If not institution, g	Bernard Ma		r.	4b. City, Town, or	Location			21, 200	
	Examin	er	2402 Dawson Stre		",		Temple I		31 000(11		cince G	
	Funeral		,		Age (in yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours		lirth Day, Year)	9. Bi	rthplace (State or Foreign country)
	Director		218-04-0077 Usual Residence of Decedent	1 ∑ M 2□F	21	Yrs.	Working Days	110010	Nov. 2			shington, D.C
	iand ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-feh	tor	Maryland Prince	George	Di	strict	Heights					1 Maryes 2 □ No
	or 28	Oirec	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	ountry?
	s 23a	rai	2815 Sydney Aven				20747				ed Stat	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Madical Examinar must be multiled at once.	by Funeral Director	Narital Status Never Married 2 Married Married 2 Married Midowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 25 If Yes, Give Year or Date	s? No			ispanic Ori in, Mexicar Specify:	gin? (Specify Yes or f n, Puerto Rican, etc.)	10-	14. Race - Am Black, Whi	ite, etc.
Maryland 21215-0036	n 72 hou natura	Completed	15. Decedent's (Specify only highest (Education		(Give	lent's Usual Occupa kind of work done of OO NOT use retired	durina mos	t of working	16b. K	kind of Business	/industry
7	withir lene. then	dwc	Elementary/Secondary (0-12)	College (1-4d	or 5+)		Wrapper	,		Dr	ivate	
<u>5</u>	i Hygi other	Be C	17. Father's Name (First, Middle, La	st)		Heat	wrapper	18. Mothe	er's Name (First, Midd			
/la	Menta Menta prked	To B	Steven B. Thoma	S				Nico	ola K. Man	n		
Man	d 2 sho th and 7 is mu traume	1 10	19a. Informant's Name/Relationship Nicola K. Middle						er or Rural Route Nurre			_
re,	ss 1 and of Healt Itam 2		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	-	ocation - City or	
Ē	Page ment c ant: If ury or		1 Burial 2 □ Cremation 3 □ Donation 5 □ Other (Special Control Con		10			1	ept. 28,2005	Lar	ndover,	MD.
Baltimore,	permit. Departi Import eny inj		21. Signature Funeral Service Lic	Sung "	70108	22	, Name and Addres	s of Facilit	Pope Fur 5558 Mar Forestv	neral rlbor ille,	o Pike	
П			23a. Part1. Enter the disease, of co shock, or heart failure. List on	mplications that caus ly one cause on each	sed the death					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Mu	tyle		ughet	- Vo	unds			Onset and Death
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	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /or	as a consequ	uence of):				_		
8760,	cate be executed chysician and the burial-transit	dical E		200 00 00 00	as a consequ	uerice or,						
9	ificate g phys as the	edic		d						I		
Box	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	-			23d. Date of de Month	olivery Day Year
, P.O.	res that the de signed by the a I be detached f	y Ph	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	nderlying cause give	en in Part I.	. 23e. Dio	tobacco	use contribute t	o the cause of death?
ıds	w requires been sign should be	ted by							1	Yes 2	□No 3□P	robably 4 Munknown
Division of Vital Records,	The law rate has be page 2 shi	Completed							per	is an opsy formed?	prior to death?	utopsy findings available completion of cause of
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			100		of Death Check only			
o	Attending Physician: or death. ector: After this certifics by the funeral director, I	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Ir		ER/Outpation 28b. Time of		4 140	rsing Home 5 Re			Scene
0	th: : Afte	tlon	1 □Natural 5 □ Pending 2 □ Accident investigat	(Month,	Y Year)	Injury	28c. Injury Work	Yes 2		+1	let	
N N	or Attenation of Control of Contr	ertification:	3 Suicide 6 Could not	be 28e. Place of		ome, farm, str	eet, factory, office	, ^	28f. Locati n City or T	(Street ar	nd Num or or Fl	ural Route Number,
۵	urs af urs af aret D	O	17.0	221		tom	doubtre	et	Tupl	- Hu	16, 144	yland
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying (2 Medical Ex	aminer: On the basis and manner	of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my op	ie, date an pinion, dea	d place, and due to the th occurred at the time	e cause(s a, date and) and manner a d place, and du	s stated. e to the cause(s)
	To the H within 24 To the F complete	ž	29b. Signature and title of certifier	, ~/ .			29c. License OCM				te signed (Mon	
0			/ peodor 1	1. Kg	of ne	w				septe	ember 21	L, 2005
2	(4)	ľ	30. Name and address of person who	o completed cause of	death (item	1 23a) (Type,	IT1 Penn	Stree	et Baltimo	ore,	Marylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 20	DE Service	strar's Signa	Spec	E)					

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ORIGINAL

1	*	_	AREA WILL IN 166 10 , 55 5	33222
4	Physicia /Medic		1. Decedent's Name (First, Middle, Last) SHUN M. MILBURN 2. Date of Death Month OCTOBER 1. 2005	3. Time of Death 1:12 P M
	Examin		4. Cit. Town and applied to Country of Donath	CO
200	Funeral Director		5. Social Security Number 6. Sex 12 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 2005) 12 2005 Washing	os (State or Foreign ngton, DC
9	r the Maryland r 286-f show	tor	NED New house Page 11 a	I. Inside City Limits 1 XYes 2 □ No
	deeth with the Maryland rms 23a or 28e-f ehow	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20853 USA	?
336	urs after deett	by	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2X No. Specify: Specify: Specify: BLack Specify:	c.
21215-0036	within 72 hours after iene. iene. r than "natural", or Ite	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Repairman 16b. Kind of Business/Indus Private	stry
Maryland 2	should be filed withind Mental Hygiene. marked other than mattic event, ITA M	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidle, Maidle, Maidle, Maidle, Maidle, Mary F. Dyson	
Man	s 1 and 2 should f Heatth and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 13322 Keating Street, Rockville, MD 20853	ode)
Baltimore.	0 0 ± 5		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cramatory or other place) Complete	ı, State
Balt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licens 22. Name and Address of Facility Bianchi 814 Upshur St. NW Washington, DC 2001	1
8760.	Physician and was provided by the prival-transit th	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiac arrhythmia associated with cardiomegaly Due to (or as a consequence of):	iterval Between
P.O. Box 68	death cer a attendin d for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
	quires that n signed b	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions of the conditions contribute to the conditions of the conditions contribute to the conditions of the conditions contribute to the conditions of the conditions contribute to the conditions of the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions conditions contributing to death but not resulting in the underlying cause given in Part I.	cause of death?
Vital Records.	: The law requir cete has been s , page 2 should	Completed	Diabetes Mellitus Seizure Disorder 24a. Was an autopsy performed? death? 1	y findings available eletion of cause of
n of Vita	Attending Physician: 7 death. r death. actor: After this certifice. by the funeral director, p	on; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2XXER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
Division of		Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - Al home, farm, street, factory, office 28f. Location (Street and Number or Rural R City or Town, State)	loute Number,
	Hospital or 124 hours efte ne Funeral Div	dical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as state (and manner stated.	
	To the within 2 To the comple	M	29b. Signature and title of certifier 29c. License number OCME 29d. Date signed (Month, Da) OCTOBER 2, 20	•
*/		H	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Marylan	nd 21201
	Sta Registr			

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year ELVIN ROBERT /Medical MYERS SEPTEMBER 27 2005 12.42p4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 ☐ F Director Yrs 205-10-2383 April 27,1919 Pennsylvania 86 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 € No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6890 Buttonwood Court 21703 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ WWII Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sale Representative Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental H Elvin Clay Myers Olive Earle Pecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. 6890 Buttonwood Ct., Frederick, Maryland 21703 Ruth Myers/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 9/29/05 `4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Frederick Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, P.A. Swelle 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease shock, or heart failure. e, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Immediate Cause (Final atheroscleratic commany artery disease Frysician disease or condition resulting in death) years /Medical Examiner perfension Sequentially list conditions, if any, leading language cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the s 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð page 2 should be diabetes mellitus 3 Probably 4 Munknown Completed A'brillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 🗌 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53129 28/05 12+WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date Heitzig M 610 Solarex Ct Frederick Degistrar's Signative 2005 Registrar

		For State Registrar	State	of Maryland / Dep <i>Ce</i>	ertificate of L			2005	33224
		1. Decedent's Name (First, Mide	tle, Last)				of Death		3. Time of Death
Physic /Med			Iris	Odean Merrike	en	Septe		ay Year 2005	10:41 PM
Exami		4a. Facility Name (If not institution	on, give street and no	umber)	4b. City, Town, or			c. County of Death	
		Washington Co				rstown		Washingto	
Funeral Director		5. Social Security Number 240-46-5227	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. last birthday 72 Yrs.	Months Days		of Birth h, Day, Year mber		nce (State or Foreign y) Carolina
and	1	Usual Residence of Decedent 10a. State 10b. Count	v	10c. City, Town or t	ocation			10	d. Inside City Limits
Aaryli sho	5				COMMON			10	1 ZYes 2 □ No
the A	Director	Maryland Wa. 10e. Street and Number	shington		Hagers 10f. Zip Code	town	100.0	itizen of What Countr	
3a or		9 South Buri	ana Plud			740	, tog. 0		у.
death me 2	Funeral	11. Marital Status	12. Was Dec			spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc	or No-	U.S.A. 14. Race - America	n Indian,
Baltimore, Maryland 21215-0036. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show eny injury or other treumatic event, the Modical Examinar must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	If Van C	21☐ No live	If Yes, specify Cubar 1 ☐ Yes 2 ☐ No		c.)	Black, White, et Specify: Whi	
21215-0036 ad within 72 hours aft giene. er then "natural", or i, the Medical Exami	ted		nt's Education	16a. Dec	edent's Usual Occupa	ution	16b. I	Kind of Business/Indu	
215 Pin 7	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed	(Giv (1-4or 5+)	e kind of work done di DO NOT use retired)	uring most of working			,
21 Salari	Com	8	00,1090	(1 40/ 54)	Homemaker			Home	
be filed tal Hygind of other	Be (17. Father's Name (First, Middle	, Last)			18. Mother's Name (First, M	iddle, Maide	n Sumame)	
aryla should I and Meni	2	Ralph Know.				Edna Goo			
Maryland nd 2 should be file th and Mental Hy 27 is marked oth treumatic event		19a. Informant's Name/Relation				nd Number or Rural Route N			
e, N 1 and Heelth em 27 ther tu		Richard D. Hurs	st (Grands	20b. Place of Disp		lvd. Hagersto	-		
Baltimore, sernit. Pages 1a Department of Hee mportent: if item my injury or othe suce.		1 Burial 2 Cremation		n State cemetery, cre	amatory or other place	,		Location - City or Tow	
Iting it. P. Sartment injury		4 □ Donation 5 □ Other (21. Signature of Funeral Service)			g Cremato:	ry October 5			
Baftil permit. F Departm importer eny injur		In The Control	E Davi			bury Ave. Smi		is Funeral	
	<	23a. Part. Enter the disease,	or complications that	caused the death. Do not en				- /	Approximate
Physician	. 1	shock, or heart failure. Lis Immediate Cause (Final	1.4					(nterval Between Onset and Death
/Medical		disease or condition resulting in death)	a U &	(or as a consequence of):					month
Examiner		Sequentially list conditions	b AC	inte Rena	ul insu	ftiency			
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8760, cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	٥.	ancveat	ic t	-umor			
8760, sate be ex hysiclan the buria	alE		33010	(or as a consequence or).					
687 tifficate ng phys as the	edical		d.						
Box 6 eath certifi	N/W	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnancy				23d. Date of delivery	,
O. B.	icla	in the past 12 months? 1 □ Yes 2 🗷 No	4☐ Preg	nant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify</i>)				ay Year
P.O. that the de	by Physician/Me	9 Unknown	9□ Unkr						
I Records, P.O. Box 6 The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant condit	- A	death but not resulting in the	underlying cause give	n in Part I. 23e.	Did tobacco	use contribute to the	cause of death?
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be or	Completed	Diaset.	25 N	ellipus	44		1 Yes 2	2 □ No 3 □ Probat	oly 4 Munknown
e 2 sl	nple	Biliary	Hepa	1, 4,2			Was an autopsy	prior to comp	y findings available of cause of
Vital Re icien: The lav certificate has ector, page 2		Severe		emia		101	performed? es 2 X N	death? o 1 ☐ Yes 2	X No
f Vital Re ysicien: The is certificate hadirector, page	Be	25. Was case referred to medic examiner?	Hospital: A	A9	Other	26. Place of Death (Check of			
Of Phys	.: To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 ER/Outpatie	ent 3LI DOA	4 Nursing Home 5	Residence ribe how inju		
on ding th. : Afte	tion	1 Natural 5 ☐ Pend 2 ☐ Accident inves		nth, Day Year) Injury	Work'	? 'es 2 □ No	noo now inje	ary occurred	
Division of a or Attending Physical death. Director: After this in by the funeral din	Certification;	3 ☐ Suicide 6 ☐ Could	I not be 28e. Plac	e of Injury - At home, farm, s ding, etc. (Specify)	treet, factory, office	28f. Locat	ion (Street a	nd Number or Rural I	Route Number,
Div	Cert	4 _ Notticue	Dulic	ding, etc. (Specify)		City o	r Town, Stat	re)	
Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) Certify	i Examiner: On the t	ie best of my knowledge, dea basis of examination and/or inner stated.	th occurred at the time nvestigation, in my opi	e, date and place, and due to inion, death occurred at the t	the cause(s ime, date an	s) and manner as stat nd place, and due to the	ed. ne cause(s)
Го th within Го th	₹	29b. Signature and title of certifi			29c. License	number	29d. Da	ate signed (Month, Da	ay, Year)
220		1 /esson	a n	1)	00.5	8181	16	13/2003	مبسر ح
n	1 8	30. Name and address of perso	who completed cau		, Print)		-		Misse
2		KODUAH PE	PRAH	382 S. Cle	veland A	ve, Hagers	town	mD2	1740
	ate	31. Date filed (Month, Day, Yea		Registrar's Signature		, ,			
Regist	7	0011	3 2005	Now & A					
Unividi 17 MeV 1/3	-001			ORIGIN	AL				

State of Maryland / Department of Health and Mental Hygien= 0.0533225 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day **JAMES** 5:00 PM RUSSELL MARKER V3801DC 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4825 Catholic Church Road Knoxville Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 17, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 72 Yrs Director 220-28-7985 Maryland 1933 Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Maryland Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4825 Catholic Church Road permit. Pages I and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a appringing or other traumatic event, the Modiful Experimentance. 21758 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Installer Heating/Air Condition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Ralph Marker Pear1 Virginia Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Marker/wife 4825 Catholic Church Road, Knnoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \(\) Burial 2 \(\) Cremation 3 \(\) Removal from State 4 \(\) Donation \(\) \(\) Other (Specify) of ☐ Other (Specify) St. Mary's Catholic Oct. 8, 2005 Knoxville, Maryland 21. Signature of Fureral Service Lions 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 R 23a. Part 1. Enter the disease on eomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician ANERR OF ESOPHAGUS TITE 2 GEALS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Cher (specify) been signed by the a should be detached (0 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Únknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 2 410 of Vital 1 ☐ Yes or Attanding Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this within 24 hours after death.

To tha Funaral Director: After thi
completely filled in by the funeral. 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 5. 2005 D10587 HOSTICE OF FREDERICK COUNTY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHITH MEDICAL 4.0 DIRECTOR 516 TRAIL AVE: FREDERICE 40. 21701 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		_	For State Registrar	State of Ma	aryland		artment of H				jiene eg. No.2	105	33226
	Physicia	an	1. Decedent's Name (First, Middle	,			***	^		2. Date of Dea Month	Day	Year	3. Time of Death
V	/Medic	al	4a. Facility Name (If not institution	JEAN			MOREIR		of Dooth	Octobe		2005	11:44 AM
	Examin	er	TI \ \	i 1 1/	1.00	1	Baltimo		L L		4c. Coun	y of Death	
	Funeral		5. Social Security Number	6. Sex 7. Ag	Spita	ast birthday)	If Under 1 Year	If Under		8. Date of Birth	Voss)	9. Birthp	lace (State or Foreign
	Director		485-52-9356	1□ M 2□XF 5	9	Yrs.	Months Days	Hours	Min.	Oct. 9	, 1945	Couin	Iowa
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside City Limits
	Maryl	ō	Virginia Fauqu	iier		mingto						1	1√2Yes 2□No
	r 28a	irec	10e. Street and Number				10f. Zip Code			-	0g. Citizen of	What Coun	
	th wit	aiD	308 N. Rappahar	nnock St.			22734				U.S.	Α.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Itam 27 is merked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Madical Exartical remains to notified at	by Funeral Director	11. Marital Status 1 Never Married 2XXMarr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: Whi	etc.
21215-0036	2 hou		15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	w = 6		16b. Kind of I	Business/Inc	flustry
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or !	i+)	lite.	kind of work done of DO NOT use retired	during mos d)	it of worki	ng			
12	filed w Hygier Athar th		12 17. Father's Name (First, Middle,	(act)		Techr	nician	19 Moth	orle Name	(First, Middle,	Teleph		
Maryland	Mental Harked of	o Be	Donald Ralph Br	•						olleen l			
<u>Z</u>	2 should and Men is marke aumatic	ို	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street						Code)
	1 and 2 Health a tam 27 is		Joao M. Moreira	1		308 N	. Rappah	annoc	k St	., Remi	ngton,	VA 2	2734
ore,	es 1 a of Hei f Itam rr othe		20a. Method of Disposition 1 □ Burial 2 🎛 Cremation	2 Demoval from State	20b. P	lace of Dispo	sition (Name of matory or other plac	ce)		ate	20c. Location	- City or To	wn, State
Ĕ	Pages ment of I tant: If Its jury or o		`4 □Donation 5 □ Other (S		Mos		matory		10/0	1.1	Varrent		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee Licensee		22	2. Name and Address 233 Broad	ss of Facili	^{ty} Mos Ave.	er Fune: , Warre	cal Hon	ne, In 7A 20	c. 186
ı.			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	I the death ne.	n. Do not ent	er the mode of dyin	ig, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hepati		/							5 years
	Examiner			Due to (or as	a consequ	uence of):)
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):						-	
	be executed sician and burial-transit	Examiner	that initiated events	C									
, 0	e exerian ar		resulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	physic the bi	dical		d									
9	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv					334 D	ate of delive	
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oats 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (s <i>pecify)</i>						Day Year
ο,	es that igned b be deta	by Pł	Part II. Other significant conditi	ons contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I		23e. Did to	bacco use cor	ntribute to th	e cause of death?
Records,	w require been sig should b									1 □ Y	es 2 No	3 🗌 Prob	ably 4 ∐Unknown
900	faw requas been 2 should	Completed								24a. Was a		Were autop	osy findings available inpletion of cause of
		Com								perfor		death?	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			04			Check on or			
of	Phys this	. To	1 ☐ Yes 2 ☒No 27. Manner of Death	1 Inpatie		ER/Outpatier 28b. Time of	t 3 DOA	er: 4 □ Nu		me 5 Resid			")
	Attanding I r death. actor: After by the funer	tion	1 Natural 5 Pendir 2 Accident investi		y Year)	Injury	Wor	k? Yes 2 □			ow injury cooo	1100	
Division	I or Attandii after death. Diractor: A I in by the fu	ifica	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of In	ury - At ho	me, farm, str	eet, factory, office			28f. Location (S	reet and Num	ber or Rura	Route Number,
ā	spital or A ours after neral Dirac filled in by	Certification;	1 Tomolog	building, el	с. (эрвспу	'/				City or Tow	i, State)		
	4 4 5 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	edical	29a. Certifier Tale Certifying Check only one	ng Physician: To the best Examiner: On the basis of and manner st	f examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	nd place, ith occurr	and due to the c ed at the time, d	ause(s) and mate and place	anner as st , and due to	ated. the cause(s)
	To the I within 2: To tha I	Σ	29b. Signature and title of certifie	_			29c. Licens			2	9d. Date sign		
,				MEDICAL				00	00		OCTOB	ER 5	2005
			30. Name and add ss of person	WILL TOHNS HODE				MOVE	ECTO	XT DA	TINIONE	140	11207
	Sta	ate.	31. Date filed (Month) Day Year	32. Paisti			WOU POPICI	4401	-11-	VVII BAL	MULKE	NIV !	11681
	Regist		0011	3 2005 See			beates						

DHMH 17 Rev 1/2001

ORIGINAL

Amend 4a per dvr 9per Th 9848 10-13-05 vt State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** Lawrence Calvin Metzner OCTOBER 4TH, 2005 21:54 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner MEMORIAL HOSPITAL tal CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. July 3, 1929 Cumber Lan 7. Age (In yrs. last birthday) 9. Birthplace (State Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1**√**M 2□F 76 Director 213-24-7278 Usual Residence of Decedent with the Marysand 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ŏ 21502 USA 231 Henderson Avenue or itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itar any Injury or othar traumatic event 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White À 3 SWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Human Resources 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Services Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Edward Metzner Vada (Dicken) Metzner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 217 Windy Lane, Hyndman, PA 15545 Joseph Metzner Son 8,05 LaVale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Lawn Mem Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licensee 1302 National Hwy., LaVale, MD 21502 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CIRRHOSIS OF THE LIVER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). requires that the death certificate be executed as the burial-fransit Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 performed? 1 ☐ Yes 2 ☑ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ŧ ۵ this hours after death.

narai Director: After this
y filled in by the funeral di 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification; t Matural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai within 24 ho To tha Fun completely 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certalier October 6, 2005 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POONAI, VIK, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

مساولوس الدوارا

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 05:30 PM John Edward Meredith September 22 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) Feb. 2, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1**⊠**M 2□F 216-16-7448 81 Yrs. Director 1924 Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or itams 23e or 28a-f show any injury or other traumatic avant, the Medical Evandrus. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Director Cambridge 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3018 Steamer Run Road 21613 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Specify: white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) project engineer state highway dept. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas V. Meredith Florence Bradlev 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Meredith wife 3018 Steamer Run Road, Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dorchester Memorial Park 9/27/05 Cambridge, ND 21. Signature a Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. lin رتما 700 Locust St., Cambridge, MD 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Overwh /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner nding physicien and see as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1□Yes 2□No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) No Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3 DOA within 24 hours after death.
To the Funeral Director; After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Confiring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) c holas an AT 2438946-F33 September 22,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inion memorial Hospital, MD Chocsi MD Nondell 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar

K**a**nisha Neal 05-06514 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene.

		,	For State Registrer	State of Ma	aryland / Depa <i>Cei</i>	tificate of De			2005	33229
80	Physicia	an	1. Decedent's Name (First, Middle					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Kanisha 4a. Facility Name (If not institution,			4b. City, Town, or Loc		Septembe	er 23, 200: 4c. County of Death	
1	Examin	ਰ। ਂ ,	Suburban Hospit			Bethesda			Montgomer	
	Funeral Director		5. Social Security Number 217-29-1106 Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 F	e (In yrs. last birthday) 15 Yrs.		Under 24 Hrs. Address Min.	B. Date of Birth (Month, Day, Y ULY II	9. Birth ,1990 Mai	place (State or Foreign nty) Lyland
	yiand now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	MD Monto	gomery	Ro	ckville				1 Yes 2 No
	th with th	ai Dire	10e. Street and Number 202 Broadwood	d Dr		10f. Zip Code 203	51	109	U.S.A.	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury ac	d by Funeral Director	11. Marital Status ★ Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 Yes 2 H If Yes, Give Year or Dates:	No	Was Decedent of Hispa f Yes, specify Cuban, N 1 ☐ Yes 2 No S		fy Yes or No- can, etc.)	14. Race - Ameri Black, White	
21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 9th	's Education t grade completed) College (1-4or 5	(Give life. I	dent's Usual Occupation kind of work done durit DO NOT use retired) Student	n ing most of working	7 1	sb. Kind of Business/Ii Montgome: Public So	cy County
	a filed other other	Be Co	17. Father's Name (First, Middle, I	Last)		18	3. Mother's Name (First, Middle, Ma	aiden Sumame)	
Maryland	should be and Mental a marked o umatic eve	To E	William	The second second					Neal	
Mar	d 2 sh th and th and traum traum		19a. Informant's Name/Relationsh Joyce D. Neal			ng Address (Street and Broadwoo				
nore,	Pages 1 and nent of Health that: If Item 27		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 Removal from State	20b. Place of Dispo	isition (Name of matory or other place) Park Cel	Da	te 20	C. Location - City or T	own, State
Baltimore,	permit. P Departme Importan any injun		4 D nation 5 Other (S. 21. Signature of Funeral Service I		1/1 22	2. Name and Address of	of Facility Sno	wden F		
A Section	2. 2.	9	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Stab	a consequence of):					Onset and Death
0	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or sta	a consequence of):					
	xecuted and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edicai E		d		_				
P.O. Box 6	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Nonown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	quires that in signed by uld be deta	þ	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	nderlying cause given ii	in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Il Records,	The law ete has b page 2 si	Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vita		Be	25. Was case referred to medicat examiner? 1 ☒ Yes 2 ☐ No	Hospital:		Other	6. Place of Death			
o	g Phys er this eral di	n: To	27. Manner of Death	1 ☐ Inpation		IL SLI DOA		e 5 Hesideni Id. Describe how	ce 6 Other (Speci r injury occurred	(y)
sion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pendin 2 Accident Investig	pation Sept 23, 20	105 20:30	OPM 1□Yes	3 2 No		t stassel)
Division of Vital	after dater d	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of In	jury - At home, farm, str ic. (Specify)	1		City or Town	set and Number or Rui State) Sed Rei , Rock	
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the best Examiner: On the basis of and manner st	of my knowledge, death	h occurred at the time,	date and place, ar	nd due to the cau	ise(s) and manner as	stated.
	To th withir To th compl	Me	29b. Signature and title of certifier	- 0		29c. License nu			d. Date signed (Month,	
	2		Jasha	Bleef	no	O.C.M.	Е.	S	September 2	4, 2005
	=== 121		30. Name and address of person Tasha Zavee	who completed cause of a		n Street,	Baltimore	e, Maryl	and 21201	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 8	2005 32 Registr	rar's Signature	uti				

			riease	State of Mary					•		9	
			1 - For State Registrar	State of Mary			ite of E		wentai ny	_	000	22220
ch	¥	THE T	Decedent's Name (First, Middle, Las	t)			10 01 2	Joann	2. Date of D	Reg. No	2005	3. Time of Death
	Physici /Medio		Jestina	T Nemb	CA.				Septembe	Da		r 0300 M
	Examir		4a. Facility Name (If not institution, give	street and number)	7	4b. Cit	y, Town, or	Location of Dea	ath	40	County of De	
		Sta.	Montgomery Gener				lney			1	Montgom	ery
	Funeral Director		5. Social Security Number 6. Se	ex 7. Age (In 50	yrs. last birthday Yrs.	Month	s Days	If Under 24 Hr Hours Mir	n. (Month, D	irth a <i>y, Year)</i>	9. Bi	nthplace (State or Foreign country)
1			216.29.7065 Usual Residence of Decedent	50		1			Oct.2,	195	4 S16	erra Leone,WA
	inylan show		10a. State 10b. County	100	c. City, Town or L	ocation						10d. Inside City Limits
	8a-1	Director	Maryland Montgome	ery	Silver							1 X Yes 2 □ No
	with ti	Ē	10e. Street and Number 1005 Rosemere Ave				Zip Code				tizen of What C	ountry?
	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-1 show calcel Exertified at	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		20904	spanic Origin? (Specify Yes or N		S.A.	erican Indian
9	or Iter	F	1 ☐ Never Married 2 🖾 Married	Armed Forces? 1 ☐ Yes 2 🖾 No		If Yes, sp	ecify Cuban	, Mexican, Pue	rto Rican, etc.)		Black, Wh	ite, etc.
303	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 L Yes	2 X No	Specify:			Specify: B	lack
21215-0036	be filed within 72 ho ital Hygiene. d other then "nature event, ine Modical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>complet</i> ed)	(Give	e kind of a	sual Occupa vork done di	tion uring most of w	orking	16b. K	and of Busines	s/Industry
12	within ene. then *	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years			use retired) ontrol	Speci	lalist	B:	anking	
	i Hygid other	BeC	17. Father's Name (First, Middle, Last)	2 icars	ria	uu o			ame (First, Middle			
<u>lar</u>	should be nd Mental marked o matic eve	ToB	Bennonine Cole					Sabin	na 0.	Tay	vlor	
Maryland	2 sho and h is ma	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Addre	ss (Street a	nd Number or F	Ru <i>ral R</i> oute Numi	ber, City	or Town, State,	Zip Code)
	and lealth m 27 her tr		Hastings Newbury	and the second of the second o					Silver	-		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menis Importent: If Item 27 Is marked any Injury or other traumatic e once.		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐	Hollicadi Itolli Orato	Ob. Place of Disp cemetery, cre				Date		ocation - City o	
Ħ	urtmer ortent		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Gate of				08/2005	Silv	er Spri	ng, MD
Ba	Depa Impo any I		A Signature of Fullerial Service Licent	+	[H]	INES-	RINAL	DI FUNE	RAL HOME	, IN	ic.	
-			23a. Part1. Enter the disease, or comp shock, or beart failure. List only	dications that caused the	death. Do not en	L800 iter the m	New Hode of dying	ampshir , such as cardi	e Ave, Sac or respiratory	SILVE arrest,	r Spri	MD 20904 Approximate
	Physician		Immediate Cause (Final disease or condition	AA i i								Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a co	nsequence of):	ham	ur Co	ell Caro	inoma			-T year
	Examiner		Sequentially list conditions,	b								
	be sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (or as a co	nsequence of).							
	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):	-						
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68	g phy as the			u.								
Box	The law requires that the death certificete to the last been signed by the attending physionage 2 should be detached for use as the topage 2.	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pr		□Estania	pregnancy				23d. Date of de	alivery
	it the deal by the att tached for	sicie	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant at time		Other (Month	Day Year
P.0	that the		9 Unknown		4				00 8:4			
ds,	signe d be d	d b	Part II. Other significant conditions co	minouring to death but no	it resulting in the l	underlying	cause giver	n in Part I.			- 1	robably 4 Unknown
O	should I	Completed							-	1		
Re	The av	E							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
Vital Records,	ician: The certificate rector, pag	0	25. Was case referred to medical					26 Place of De		2 X No		
Ž	ysici is cer direci	To B	examiner? 1 □ Yes 2 No	Hospital:	2 ER/Outpatie	nt 3∐ [Othor		Home 5 Res	_	6 ∏Other (So	acify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	of	28c. Injury Work		28d. Describe			,,
sio	Attendideath. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2 No				
Division	or Attend after death Director: A	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, facto	ory, office		28f. Location City or To	(Street ar wn, State	nd Number or F e)	Rural Route Number,
	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificitied in by the funeral director.		29a. Certifier Certifying Ph	/sician: To the best of my	knowledge dos	th coours	d at the time	dete and slee				
	• Hos	Medical	(Check only 2 Medical Examone)	iner: On the basis of exa and manner stated.	mination and/or in	rvestigatio	on, in my opi	nion, death occ	curred at the time	date an) and manner a d place, and du	s stated. e to the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Da	te signed (Mon	th, Day, Year)
)	10		Paul Barrer				MD OIN	335		C-01		24 2005
			30. Name and address of person who o	completed cause of death	(Item 23a) (Type	Print)	Paul .	A. Bann	en, M.D.	Jent	einner	2 4 2005
			31. Date filed (Month, Day, Year)	1: p Dr # 32	7 01	Ney.	MD	20832				
	Sta Registi		SEP 2 8 20	32 Registrar's 5	oignature	de						
8.8	A.		O21 ~ O EU	The state of the s	-							

		1 - For State Registrar		artment of He	Death	Reg. (ne 2005 3323
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Tiajuana Ela 4a. Facility Name (If not institution, give s Washington Adventi	ine Nailing street and number)	4b. City, Town, or Takoma 1	Location of Death	September	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 08/17/195	Montgomery 9. Birthplace (State or Foreign Country) Washington, DC
27215-UU36 4 within 72 hours after death with the Maryland jiene. rithen "naturel", or Items 23a or 28a-f show the Marical Examir or must be notified at the Marical Examir or must be notified at	/ Funeral Director	10a. State 10b. County Maryland Prince Ger 10e. Street and Number 3324 Chauncey Place 11. Marital Status 1 □ Never Married 2 ★ Married	ce # 201		panic Origin? (Spec , Mexican, Puerto R Specify:		10d. Inside City Limits 1 ☐ Yes 2気 No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc.
and 2121 be filed within ntal Hygiene. od other then "	Be Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	Year or Dates: cation a completed) College (1-4or 5+) 16a. Dece (Give life.	odent's Usual Occupat b kind of work done du DO NOT use retired)	tion uring most of working 18. Mother's Name	De	
Battimore, Maryland permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event once.	To	George Wooten 19a. Informant's Name/Relationship (Ty. Johnny A. Nailing 20a. Method of Disposition 1	Jr./husband 3324 Jemoval from State 20b. Place of Dispresentery, cree Fort Line	Chauncey Fosition (Name of matory or other place) oln Cemete 2. Name and Address	Place #20] Da Place #20] Place #2	Mt. Rai te 20c. 2005 Bre	mpbell y or Town, State, Zip Code) ner, MD 20712 Location - City or Town, State ntwood, MD Funeral Home od, Md 20722
be executed /Medical /Medical Examiner Institution	Examiner	23a. Pant. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				Approximate Interval Between Onset and Death
death certificate attending phy:	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at time of death / 5[9□ Unknown	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year
The law requires The law seen sign page 2 should be	Completed by	NON - HOO	Arributing to death but not resulting in the u	Inderlying cause giver	n in Part I.	23e. Did tobacci	24b. Were autopsy findings available prior to completion of cause of death?
ding Phy	ertification: To Be	27. Mainer of D ath Natural 5 Pending 2 Accident investigation	lospital: 2 ER/Outpatient 2 ER/Outpatient 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury	nt 3□ DOA Cther of 28c. Injury a Work?	4 INUISING Home		6 ☐Other (Specify) jury occurred
Hospitel or 4 hours afte Funerel Dir ely filled in I	edical Certific	3 Suicide 4 Homicide 29a. Certifier (Check only one) (Check Description one) (Check Description one) (Check Description one)	28e. Place of Injury - At home, farm, st building, etc. (Specify) sician: To the best of my knowledge, deat her: On the basis of examination and/or in and many states.	h occurred at the time	date and place, an	City or Town, Sta	(c) and manner as stated
To the within 2 for the complete	Med	29b. Signature and title or pertilier	and manner stated. The stated of death (Item 23a) (Type, Note that the state of death (Item 23a) (Type, Note that the	29c. License	umber UMA	29d. [Date signed (Month, Day, Year)
St. Regist	ate rar	31. Date filed (Month, Day, Year) SEP 3 0 2005	NEWSSIE M- 32. Registrat's Signature	0 (Wodhus	ston A	Wented Hoge

			1 - State Registrar	State of Maryla		artment of H			ene 2005	33232
	Physici /Medic		1. Decedent's Name (First, Middle, Last	, Nels	%0∧			2. Date of Death Month		3. Time of Death
#	Examir		4a. Facility Name (If not institution, give Constal Hospice at 5. Social Security Number 6. Se	theLake	s. last birthday)	4b. City, Town, or Salis by			4c. County of Dea	S
<i>)#</i>	Funeral Director			THE STITE	6 Yrs.	Months Days	Hours Mir	8. Date of Birth (Month, Day, 10-14-1		thplace (State or Foreign buntry) MARYLAND
	Marylan	tor	10a. State 10b. County MD WICOMIO		City, Town or Lo					10d. Inside City Limits
	with the	Direc	10e. Street and Number		10222011	10f. Zip Code		10	g. Citizen of What Co	ountry?
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examinal relational be notified at	by Funeral Director	111 SCHOOL STREET 11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:			826 spanic Origin? (n, Mexican, Pue Specity:	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Ame Black, Whit	
21215-0036	I within 72 ho iene. r then "neturi	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of w	orking	6b. Kind of Business	,
	d be filed antal Hygi ed other c event, II	Be	17. Father's Name (First, Middle, Last) WALTER J. TILGHMAN	J	1 00	JORI OBBIG	18. Mother's Na	ame (First, Middle, M		INNTEN I
Maryland	2 should to and Ment is marked raumatic	우	19a. Informant's Name/Relationship (T)	rpe, Print)			and Number or F		City or Town, State, 2	
	of Health of Health I item 27 r other to		JAMES D. GORDY - S 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	20b.	Place of Dispo	DIXON RO sition (Name of matory or other place	1		RYLAND 218 Oc. Location - City or	
altimore,	permit. Pages Department of h importent: if its eny injury or of		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	HE		METERY Name and Addres	09-	29-2005 H	EBRON, MAR RAL HOME,	YLAND
ä	Depar impo impo eny ir		Melisin 1	Hermany		05 EAST M	IAIN STR	EET, SALIS	BURY,MARYL	AND 21804
	e Physician		23a. Part Enter the disease, or complesheck, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the dene cause on each line.			-		st,	Approximate Interval Between Onset and Death
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8760,	cate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conse	equence of);					
O. Box 6	The law requires that the death certificalle has been signed by the attending plage 2 should be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3[Ectopic pregnancy Other (specify)			23d. Date of dei Month	ivery Day Year
<u> </u>	quires that n signed b uld be deta	þ	Part II. Dther significant conditions con	ntributing to death but not re	esulting in the u	ndertying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,		Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	topsy findings available completion of cause of
Zit Zit	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	ris .	Home 5 Residen	ce 6 Other (Spec	pity) He Spiciz
ion of	ling After funer	atlon: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		1/6:3/14/2
Divis	s after de s after de ai Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical (29a. Certifier (Check only one) Certifying Phy	sician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, death	n occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
\	within To the	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Monti	
,	B.		30. Name and address of person who co	ompleted cause of death (Ite	am 23a) (Type.		5841	C	9/25/3	· J
	1/2		31. Date filed (Month, Day, Year)	RIS 2626	6 1	Mon w	(0)	T. SHLI	SBURY	(m) 21801
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State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Clifford Frank Owen September 24,2005 6:00pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6520 Wiscasset RD Montgomery Bethesda 8. Date of Birth (Month, Day, Year) Nov 22,1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□F Months 225-52-2261 79 Yrs Great Britain Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinatinal be notified at XXYes 2 □ No Director MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6520 Wiscasset Rd 20816 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Economist World Bank Injury or other traumatic event, permit. Pages 1 and 2 should be fit Department of Health and Menial Hy Important: If item 27 is marked other any Injury of Albert traumatic avents 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) May Trott Ernest Owen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Adela Owen/ Wife 6520 Wiscasset Rd., Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mt. Comfort Crematory 9-30-05 Alexandria, VA 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Licensee De Mifiles 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myeloproliferative Disorder **Physician** /Medical Due to (or as a consequence of) Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit Gastrointestinal Hemorrhage and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page 2 this certificate Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 27. Magner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 5 Pending death. investigation 2 Accident s after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Z To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0030484 September 28,2005 500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Umosella, M.D. 7625 Wisconsin Ave, N.W. #101 Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 29 2005 Jacob . Registrar

		For State Registrar	State of Mar		artment of H			giene Reg. No.2	005	33234
Dhysia	ian	1. Decedent's Name (First, Middle, L	.ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
Physic /Med				rsons			Septemb	per 24	2005	1:15 P
Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of De	ath		nty of Death	
Funeral		5. Social Security Number 6.		(In yrs. last birthday)	Delmar If Under 1 Year	If Under 24 H	rs. 8. Date of Birt		LCOMico	
Funeral Director		218-34-3253	1□M 22 F 67		Months Days	Hours M	in. (Month Day	(1938)	Del	lace (State or Foreign try) aware
pug 🔉		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or Lo	neation				11	0d. Inside City Limits
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n the	Director	10e. Street and Number		201	10f. Zip Code			10g. Citizen o	of What Coun	try?
iled within 72 hours after death with the Maryland Hygiene. Hygiene. wither then "naturel", or Itame 23a or 28a-f show ont, the Medical Examinar must be notified at	aiD	204 S. Maryland	Ave.		21875	5		USA		
er dea	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. R	ace - Americ lack, White,	
Ir, or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spec	oity: wh:	ite
72 hou	ted	15. Decedent's		16a. Dece	dent's Usual Occupa	ation	undina	16b. Kind of	Business/Inc	lustry
ithin dithin	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired	()	vorking	Clothi	na Mar	nufacturing
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d be ld be ental	To Be	Sylvester Green					Grace Rer		umoj	
ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If I tem 27 is marked other than "natural", or Itame 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship					Rural Route Numbe			Code)
and 2 leaith a m 27 ls		Robert D. Parso	ns II/son	12		rland Av	re., Delma	er, MD	21875	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre once.		20a. Method of Disposition 1 Durial 2 Cremation 3	Removal from State		matory or other plac		Date /OF	20c. Location		
iit. Pa irtmer injury		*4 □ Donation 5 □ Other (Spec			Cremator 2. Name and Addres		/27/05	Salis	bury,	MD
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Physician		Immediate Cause (Final disease or condition	mit	antatre	. lumo	n Co	1			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		1				61170
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uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
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atten affor u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
t the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
gned gned be del	by P	Part II. Other significant conditions	contributing to death but	not resulting in the u	indertying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
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sician: The law s certificate has t lirector, page 2 s	O							20 No	death?	2 🗆 No
Physician: rthis certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 No.	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Othe	AC.	eath <i>(Check only or</i> Home Resid		that (Const.	
g Physical this neral dil	-	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o			28d. Describe h)
anding lasth.	atio	1/Natural 5 ☐ Pending 2 ☐ Accident investigati	ion	rear) Injury		Yes 2 □ No				
or Atter de lirecte	Certification:	3 Suicide 6 Could not 4 Homicide determine		r - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Number,
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a Certifier 17 Certifying I	Physician: To the best of	my knowledge dest	h occurred at the time	ne date and at-	ce and due to the	21100/0)	nannas ca st	atad
e Hos 24 hc	edicai	(Check only 2 Medical Ex	eminer: On the basis of e and manner state	xamination and/or in	vestigation, in my op	oinion, death oc	curred at the time, d	ause(s) and r late and place	and due to	the cause(s)
To th Comp	Me	29b. Signature an art of certifier	. ^^^		29c. License	number	24 - 2	29d. Date sign	ned (Month, L	Day, Year)
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٧)	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	- WW	YUVUL	74 14	VIIIM	vmy	YIIU
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	/Medic Examin		4a. Facility Name (If not institution, give		Chru	4b. City, Town, o	or Location of Death		4c. County of De	ath .
	Funeral Director		~06 -06 -0438 ·	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h, Year) 9. Bi	irthplace (State or Foreign Country)
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	with a	I Direc	10e. Street and Number 27455 Edgeward			10f. Zip Code	01		10g. Citizen of What C	Country?
336	hours after death ural', or Itema 23 Il Examiner mural	by Funeral Director	11. Marital Status 1 Never Married Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Arr Black, Wh Specify:	
1215-0036	s within 72 hor giene. Ir then "neture Ir e Medical E	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of word)		Bourles	
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Baltimore	permit Pag Department Important: any injury o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens	Rounds	Pringh	Name and Addre	tery OCT ess of Facility B TSabell	Laces ast -S	- /	neral Home and 21801
	Physician / Medical physician and physician	dicai Examiner	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	Sequence of): Sequence of): Sequence of):	er the mode of dyill	Recei	for respiratory ar	rest,	Approximate Interval Between Onset and Death
.O. Box 68	death certific e attending p od for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnance Other (specify)	у		23d. Date of de Month	elivery Day Year
a	w requires that the been signed by th should be detache	ed by Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute f	to the cause of death?
Division of Vital Records,	The law ate has b page 2 sl	Complet	Dio Les	te Nep	lsoga,	tly		24a. Was a autop perfor 1 Yes	sy prior to	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		t 3CI DOA Ott		th Check only or		
ion of	E je	ation: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injui	4 🗀 Nursing 🗆		ence 6 □Other (Spe ow injury occurred	ecify)
Divis	To the Hospital or Attendi wilhin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Sp	eciry)			City or Tow		
	ne Hosp n 24 ho ne Fune bietely fi	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Examone)	rsician: To the best of my iner. On the basis of exam and manner stated.	knowledge, death nination and/or in-	n occurred at the til vestigation, in my o	me, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Mithin Mithin To the company of the	2	29b. Signature and title of certifier	6 5/	(au) un	29c. Licens	-2035		29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who o	ompleted cause of death (Item 23a) (Type,				Sitter	Schopy Stay
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2	32. Registrar's Si	ignature		10 Wize		SUR JY	MISSER

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33236 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month September 26,2005 **Physician** OK PARK 800 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 29,1959 9. Birthplace (State or Foreign 1 ☐ M 2 🛛 F Director 212-43-0588 46 Vrs Korea Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or iteme 23a or 28e-f ehow treumatic event, the Medical Examination and Legislad al 10d, Inside City Limits Md. Montgomery Gaithersburg Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 15604 Fellowship Way 20878 deeth by Funeral Korea 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or iter eny injury or other treumatic event, the Medical Exert in once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Muchul Jung Chun-Shim Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dong Ho Park (Husband) 15604 Fellowship Way Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 29, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Mem. Park * 4 ☐ Donation 5 ☐ Other (Specify) Olney, Md. 2005 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastrinteshno u unte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the attending physicien and thed for use as the burial-transit requires that the death certificate be executed coa gulora Me Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Onknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Herahhis Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 1 🗌 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 059929 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aaron Snyder M.D. 9901 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 2005 Registrar

			1 - For State Registrar	State of M	arylan	d / Depa <i>Cer</i>	artmer <i>tifica</i> i	nt of H	ealth a D <i>eath</i>	ind Me	ental Hyg	giene Reg. No. 200	
	Physic /Medi		Decedent's Name (First, Middle, Last Otto Preuss)							Date of Dea Month	ath	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Woodside Center	street and number)				Location of Spring	f Death		4c. County of D	Death
	Funeral Director		5. Social Security Number 6. Se 182-34-0706 15 Usual Residence of Decedent	X 7. A. 3 M 2 □ F	ge (In yrs. I	ast birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day Oct. 4,	h v, Year) 9.	Birthplace (State or Foreign Country) ermany
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show montaining on the recumalic event, the Madical Examinar must be notilised at once.	y Funeral Director	10a. State 10b. County DC N/A 10e. Street and Number P.O. Box 29290 11. Marital Status 1 ☑ Never Married 2 ☐ Marned	12. Was Decedent Armed Forces' 1 [] Yes 2 [] If Yes, Give	Ever in U.S		10f. Zip	0017 dent of His cify Cubar		in? (Specif Puerto Rid	fy Yes or No- can, etc.)		American Indian, Vhite, etc.
Maryland 21215-0036	uid be filed within 72 hours Aental Hygiene. rked other then "natural", tic event, the Madical Ex-	To Be Completed by	3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12) Unknown 17. Father's Name (First, Middle, Last) Unknown	Year or Dates:	5+)	16a. Deced (Give life. L	ent's Usu	al Occupa ork done d se retired)	tion uring most of			Specify: 16b. Kind of Busine Manual Maiden Surname)	ess/Industry
Baltimore, Mary	permit. Pages 1 end 2 shot Department of Health and N Important: If Item 27 is ma eny injury or other treuma once.		19a. Informant's Name/Relationship (T) Rev. James Menkhu 20a. Method of Disposition 1 DeBurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Peneral Service Licens	ns/ Friend	20b. Pl.	4121 ace of Disposementery, creme e of Hea	Hare sition (Name atory or o ven Co Name and ranci	ewood me of other place emeter and Address Ls J.	Road Road Solution Solu	or Rural F I, NE, Date ept 2005	Washi 29, 5	l Home Ind	C 20017 orTown State ring, Maryland
8760,	death certificate be executed By Aman We attending physicien and and tor use as the burial-transit After the property of th	dical Examiner	23a. Part1. Enter the disease, or common shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Securities and the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Motist. Due to (or as Due to (or as	a consequ a consequ a consequ	Small ence of): oma of ence of):	Coll	Lung	Canc		espiratory arr	est.	Approximate Interval Between Onset and Death Months Months
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Vital Records, P.	e law requires the hes been signed je 2 should be de	Completed by Ph	Part II. Other significant conditions cor	ntributing to death b	ut not resul	lting in the un	derlying c	ause givei	n in Part I.			n 24b. Were	e to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of its
Division of Vital	ding Physicien: h. After this certific funeral director,	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	ry :	R/Outpatient 28b. Time of Injury		8c. Injury Work	4 🔀 Nurs	sing Home			res 2□ No
	spitel or ours afte neral Dir filled in	al Certification:	3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physics 1 Madded Supplies	28e. Place of Inibuilding, et	of my know	vledge death	occurred :	at the time	a, date and	place and	City or Town	o, State)	Rural Route Number,
)	To the Hos within 24 h To the Fur completely	Medicai	29b. Signature and title of certifier Sau ma	ner: On the basis of and manner st	t examination	on and/or inve	estigation,	in my opi	nion, death number	occurred	at the time, da	ate and place, and c	due to the cause(s)
3	Sta		30. Name and address of person who co Saima Khawaja, M. 31. Date filed (Month, Day, Year)	D. 11119 32. Registr	Rock		Pike	, Su	ite 10	00, R	ockvil	September 1e, MD 20	
-	Registr	ar	SEP 2 8 2005	Pill of Allen	, AS	19							

			1 - For Stata Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth ai Death	nd Mental	Hygien	Z 1111	5	33238
	Physici /Medic		Decedent's Name (First, Middle, L Kenneth L.	,					2. Date of Month	D	28, 20		3. Time of Death 6:23P M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	*	a1	4b. City, Town, or Westmin			4	c. County of E	eath	
	Funeral Director		217-32-1520	Sex 7. 1 XM 2 ☐ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		n, Day, Yea	7	Count	ace (State or Foreign n) Land
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	erv		y, Town or Lo						10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Direc	10e. Street and Number 17609 Roger Driv	•			10f. Zip Code 208	7/			itizen of What	Count	ry?
980	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or flems 23s or 28s-f show event, I're Madical Exertirer must be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceding Armed Force 1 Tyes 2 If Yes, Given Year or Date	es? E_No	1	Vas Decedent of His Yes, specify Cubar		n? (Specify Yes o Puerto Rican, etc		14. Race - A Black, W Specify:		tc.
Maryland 21215-0036	e filed within 72 ha al Hygiene. other than "natu vent, Ire Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired) Denter	tion u <i>ring m</i> ost o	of working		Kind of Busine		istry
yland	2 should be fill and Mental Hy Is marked oth raumatic even	To Be	17. Father's Name (First, Middle, Last Melvin Price	e				Et	s Name (First, Mi hel Horr	nan	,		
	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other traumatic e OREs.		19a. Informant's Name/Relationship B. Marie Price - 20a. Method of Disposition		20h B	17609	g Address (Street a Roger D sition (Name of		Germant	own, l	Marylan	d 2	0874
Baltimore,	it. Pages rtment of I rtent: If it njury or o		1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Co. 21. Signature of Fune) all Services in	ity)	ate C	nantowi	n Baptist	Cemet		. 1, 2		rma	ntown, Md.
Ba	Dermi Depa Impo any is		23a. Part 1. Enter the disease, or co	Wille	ent the death	2	Name and Address	e Road	l, Dama:	scus,		nd	20872
H	Prrysician /Medical		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a	as a consequ	42014			e 770 N	ry arrest,		1	Approximate nterval Between Onset and Death
8760,	Examiner bhysician and bhysician and sthe burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Et al. James Cause (Disease or injury that intiated events resulting in death) Last	b. Due to (or	as a consequal	uence of):							
.O. Box 6	death certif e attending id for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Fetal it at time of de	death 3 [Ectopic pregnancy Other (specify)				23d. Date of Month		y Pay Year
rds, P	sign sign d be	by	Part II. Dther significent conditions	contributing to deat	th but not resu	ilting in the un	derlying cause give	n in Part I.		Did tobacco			cause of death?
al Record	The law ate has b page 2 s	Completed							— a	Vas an lutopsy lerformed? es 2X No	prior t death	o comp	y findings available pletion of cause of
sion of Vital	Attending Physician: The death. ector: After this certificate by the funeral director, pages	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigative investigative.	on		ER/Outpatient 28b. Time of Injury	3 DOA Other	4 ☐ Nursi		lesidence	6 □Other (S	oecify)	
Division	itel or Atten rs after deat al Director; led in by the	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At ho, , etc. (Specify	me, farm, stre	et, factory, office			on (Street a Town, State		Rural F	Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	hysician: To the be miner: On the basi and manner	s or examinati	vledge, death ion and/or inv	occurred at the time estigation, in my opi	nion, death	place, and due to occurred at the ti	ne, date an	d place, and d	ue to th	ne cause(s)
)			29b. Signature and title of certifie	th			29c. License		861		ite signed (Mo		
	5		30. Name and address of person who Richard Silva		of death (Item 9715 M	^{23a)} (Type, F edical					tember aryland		
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 3 0 20	Jo Reg	istrar's Signat	Spe	W						

			1 - For Starte Registrer	State of Marylar			f Health a of Death	ind Mei		ene : No 2 0 0 !	5 33330
			Decedent's Name (First, Middle, Las	t)		timodio c	Douin	2.	Date of Death	NOL UU	3. Time of Death
	Physic /Medi		William A. F	eterson, SF	١.				Month Septem	Day Yea	2005 13:55
1	Exami		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of	Death	осросы	4c. County of De	
			516 Elk Mills				Mills			Cec	i1
١	Funeral Director		210-20-7343	7. Age (In yrs. 75	last birthday) Yrs.	Months Da	ys Hours	Min.	Date of Birth (Month, Day, Y	(ear) 9,1929	Sirthplace (State or Foreign Country) MD
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d Inside City I :- it-
	Maryi	ō	MD Cecil		lk Mi						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	1 the	Funeral Director	10e. Street and Number		IK MI.	10f. Zio Cod	e		100	g. Citizen of What	21
	h with	0	516 E1k M	ille Pd		219	20			U.S.A.	
	da da	Jer.	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Vas Decedent	of Hispanic Orig	in? (Specify	Yes or No-	14. Race - Ar	merican Indian,
36	or it	Ę.	1 Never Married 2 Married	N Yes 2 No If Yes, Give Year or Dates: 195		Tes, specify C	uban, Mexican,	Fuerto Aic	ап, өкс.)	Black, Wi	
Ş	hours after death with the Maryland tural', or Itama 23a or 28a-f ahow all Examinar must be notified at	d by	3 Widowed 4 Divorced							Specify:	White
215-0036	within 72 ana. than "nai	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Deced (Give	lent's Usual Oc kind of work do DO NOT use rei	cupation ne during most tired)	of working	16	b. Kind of Busines	ss/Industry
212	ylana.	E	Elementary/Secondary (0-12)	College (1-4or 5+)			n Work			Chrycle	er Corp.
	be filad tai Hygli d other	BeC	17. Father's Name (First, Middle, Last)						irst, Middle, Ma	iden Sumame)	er corp.
Val	should be ind Mantai a markad umatic av	2	Lewis A. Pet	erson			Ann	ie M	ae Rot	hwell	
Maryland	s 1 end 2 should be filiad within 72 hours after dasth with the Maryian if Health and Mantal Hyglans. Itam 27 is marked other than "natural", or Itama 23s or 28s-f show other traumatic event, the Medical Exeminer must be notified as		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Stre	et and Number	or Rurai R	oute Number, C	City or Town, State	. Zip Code)
	1 end Jeaith am 27 thar tr		William A. Peto 20a. Method of Disposition		8 Ama	aranth	Drive				
و	nt of h		1 ဩBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cren	natory or other	place) S	Date ept.	30	c. Location - City of	
altimore,	parmit. Page Dapertmant of Important: If any injury or once.		 *4 □Donation 5 □ Other (Specify, 21. Signature of Fuperal Service Licens 				emeter		05	Elkton,	MD
Ba	parmit. Pages 1 end 2 Dapertmant of Health a Important: if itam 27 is any injury or othar trai		1260		4		G. Gee		eral H	Iome	
			23a. Part1. Enter the disease, or comp	lications that caused the deat	h. Do not ente	or the mode of o	Main S	ardiac or re	E1kton spiratory arrest	, MD 2	1 921 Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	1						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):	neg					1 molls
н	Examiner		Sequentially list conditions,	b							
	De is	Exeminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
_	xecut and	Xen	that initiated events resulting in death) Last	c Due to (or as a conseq.	uence of):						
8760,	icete be executed physician and s the burial-trensit	dicel E		4	,						
9	ifficete g phy	be		u							
Box	attanding p	M_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		eUL WING				23d. Date of d	elivery
-	The law requires that the deeth certificate has been signed by the attending I ate has been signed by the attending I agga 2 should be detached for use ea	Physicien/Me	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of d		Ectopic pregna Other (specify)				Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown								
	iras tha signed t be de	ğ	Part It. Other significant conditions co	nthouting to death but not resi	ulting in the un	derlying cause	given in Part I.				to the cause of death?
Records,	w requir been s should	Completed						-	1 🗌 Yes	2 NO 3 X	Probably 4 Unknown
Rec	Thalaw cate has l	ם						_	24a. Was an autopsy performer	prior to	autopsy findings available completion of cause of
Vital		ပိ	25. Was case referred to medical						1□ Yes 2V		
Š	w 15	To B	examiner?	lospital: 1 Inpatient 2 I	ER/Outpatient	3□ DOA)ther		Providence	e 6 □Other (Sp.	
ot	ding Phi h. After thi funarai		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. In				injury occurred	өспу)
5	Attanding F ar death. ractor: After by the funar	910	2 Accident 5 Pending investigation	(MONIN, Day 18al)	Injury		ronk? ∐Yes 2∐No	0			
Division	or Attano after death Director: In by the	Certificetion;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, offic	ee	28f.	Location (Stree City or Town, S	at and Number or F	Rural Route Number,
0	urs af urs af aral D		00 0 m of the contract							5.50.5	
	To the Hospital or At within 24 hours after d To the Funeral Direct compietely filled in by	Medicel	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or invi	occurred at the estigation, in m	time, date and y opinion, death	place, and o occurred a	due to the caus t the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	vithin o the	Me	29b. Signature and title of certifier		•	29c. Lice	nse number		29d.	Date signed (Mon	th. Dav. Year)
	,- > F 0		> W Fork	ias ND		· n -	15314		50	today >	9 2005
j.	LIVA		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, F	Print)	7			runs 2	1 2003
U	1 1 464		H. Farkas, M.	ompleted cause of death (Item SCSONS 32. Registrar's Signal	North	era Ch	esapea	be H	ospice	Elkt	on M
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture		- /				
9	Registi	ar	SEP 3 n 2005	lace to A	and a						

			For State Registrar	State of Maryland / Depa	artment of Health an	d Mental Hygie	ne 2005 33240
Ź	Physicia	75.1	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al i	Gladys J.	Pinkney	45 City Town or Location of D	September	r 26 2005 7:00 P M
- S	Examin	er	4a. Facility Name (If not institution, give str Southern Maryland		4b. City, Town, or Location of D Clinton	eath	Prince George's
***	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		578-28-8019	M 2 1 Yrs. Yrs.	Months Days Hours M	July 13	
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Marylis f eho	ō	MD Prince Geo	orge's District	Unighta		1★ Yes 2 No
	r 28a-	Director	10e. Street and Number	rige s District	10f. Zip Code	10g	. Citizen of What Country?
	th with	aiD	2610 Mellveal Aven	ue	20747		U.S.A.
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or itama 23a or 28a-f ehow any injury or other traumatic event, the Moderni Examiner must be multiled at once.	y Funeral	1 ☐ Never Married 2 ☐ Married	1 ∐ Yes 21 No If Yes, Give	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	hours turai',	ed by	3 Widowed 4 Divorced	Year or Dates:	dent's Usual Occupation	16	Black b. Kind of Business/Industry
7	in 72	olete	15. Decedent's Educa (Specify only highest grade	completed) (Give	kind of work done during most of DO NOT use retired)	working	3. Killa di Basillessallidastry
212	d with giene. rr ther	Completed	Elementary/Secondary (0-12) 10th	College (1-4or 5+)	ouse Wife		Private
힏	e file al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)			Name (First, Middle, Ma	·
<u>Sa</u>	ould b Ments arked	2		Sr.		Plorence Pin	
Mar	12 sh h and 7 is m traum		Joseph Spencer/Bi		ng Address (Street and Number o		Igts, Maryland 20747
6	1 and Healt tam 2	1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of		c. Location - City or Town, State
5	ages ent of nt: If it		1 ABurial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place) ction Cemetery 1	0-3-05 C1	inton,Maryland
Baltimore, Maryland	permit. F Departm Importar any injui		21. Signature of Funeral Service/Licensee	2	2. Name and Address of Facility	J. B. Jenki	ns Funeral Home , Maryland 20785
1			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not en			
	Physician		Immediate Cause (Final disease or condition	Acute Myscerch	of Intuchan		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):			
74	Examiner		Sequentially list conditions, b.	Policina Citica			
	ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (un as a consequence of).			
	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	calE	d				
9	tificat ng phy as the		· · · · · · · · · · · · · · · · · · ·	11, 2000, 11000, 110000, 11000, 11000, 11000, 11000, 11000, 11000, 11000, 11000, 1100			
Box	death certific e attending pl ed for use as t	an/h	23b. was decedent pregnant	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3[□Ectopic pregnancy		23d. Date of delivery Month Day Year
O. E	ie dea the at hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 5[9☐Unknown	Other (specify)		Works Bay Four
P.0.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions conti	ributing to death but not resulting in the (underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Records,	uires signi ld be	d by	Aprila premou	14		1 ☐ Yes	No 3 Probably 4 Unknown
00	w require s been si	Completed	N			24a. Was an	24b. Were autopsy findings available
Re	0 2 0	E o				= autopsy performe 1 ☐ Yes ⊋ ☐	d? prior to completion of cause of death? No 1 □ Yes 2 □ No
of Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		26. Place of	Death (Check only one)	
<u>×</u>	Physician: this certific	2	1 ☐ Yes 2 ☐ No	spital: 1 propatient 2 ER/Outpatie		ng Home 5 Residence	
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred
Division	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, si			et and Number or Rural Route Number.
Ď	5 # 5 E	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, S	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	oian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and provestigation, in my opinion, death	place, and due to the caus occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title globeritier	4.5	29c. License number	29d	Date signed (Month, Day, Year)
	14		> Nah	(A)	20055120	J	4/ 26 2005
	Ge		30 Name and address of person who con hichard falme Mij	npleted cause of death (Item 23a) (Type 13 2 & Jonhum Av. 32. Reoletrar's Sirbature	Print) come Suite 310	was hing how	DC ZW32
100	Sta Regist	ate rar	SEP 3 Octo 2005	32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Day Sister Geraldine Quinlan October 6, 2005 4:30 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death 4c. County of Death Examiner St. Vincent Care Center Emmitsburg Frederick If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 ☑ F Yrs Director 211-42-1123 84 May 11, 1921 New York Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Frederick Emmitsburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21727 U.S.A. Funeral 335 South Seton Avenue 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Religious Community College 5+ Teacher Notre Dame de Namur

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be 2 Francis Joseph Quinlan Sarah Marley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sister Camilla Harant 333 S. Seton Avenue, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SISTERS OF NOTRE DAME 10/10/2005 ILCHESTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner 0 Physician/Medical Examiner YEAR the deeth certificete be executed ettending physician end for use as the bunel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. this certificete has been signed by the rail director, page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: after death.
Director: After this certifice funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0044037 OCTOBER 7, 2005 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Pigistrar's Signal

POR

DHMH 16 Rev 6/95

		1 - State Registrar	Pepartment of Health and Me Certificate of Death	ental Hygiene Reg. No 2005	33242
Physic /Med		Decedent's Name (First, Middle, Last) Sherman Ross		2. Date of Death Month Day Year 09 23 200	3. Time of Death 1:24 P M
Exam Funera		4a. Facility Name (If not institution, give street and number) 382 Russell Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	4b. City, Town, or Location of Death Gaithersburg hday) If Under 1 Year If Under 24 Hrs. Is	4c. County of Death	: y
Directo		0.68-1.2-33.24 1⊠ M 2 □ F 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	rrs.	(Month, Day, Year) Cou 01/01/1919 New	
the Maryla 28a-f shor	ector	Maryland Montgomery Gaithe	rsburg	10 000 - 100	10d. Inside City Limits 1 XYes 2 No
15-0036 n 72 hours after death with the Maryland "naturel; or Items 23a or 28a-f show culcal Examiner must be notilized at	by Funeral Director	382 Russell Avenue 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Yes	10f. Zip Code 20877 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ify Yes or Nocan, etc.) 10g. Citizen of What Cou USA 14. Race - Amer Black, White Specify: Wh:	ican Indian, , etc.
- c * 3	Completed b	1 3 □ Widowed 4 □ Divorced Year or Dates: T.T.T T T	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16h Kind of Business/fr	ndustry
Itimore, Maryland 212 It Pages 1 and 2 should be filed within Artment of Health and Mental Hygiene. Artman: If item 271s marked other then hipry ocother traumatic event, ITEM	To Be C	17. Father's Name (First, Middle, Last) Max Rosenblatt	18. Mother's Name (Rachel K Mailing Address (Street and Number or Rural is		p Code)
Baltimore, M Dermit. Pages 1 and 2 Department of Health inportant: If item 271 any nijery ocether tra	-	20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Bernoval from State 20b. Place of cametery	2 Russell Ave, Gaither: Disposition (Name of v. crematory or other place) incoln Crematory 09/	20c. Location - City or T	
Dant. Departm Importa any hip		21. Signature of Funeral Service Literisee Chu Line Land - Nody 23a. Part 1. Enter the disease, o complications that caused the leath. Do not be seen to	22. Name and Address of Facility Simple Tribute Funer 1040 Rockville Pike.	al and Crematio C	enter
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	Leens caren	espiratory arrest,	Interval Between Onset and Death
of ou, cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequence	<i>(</i>		
the death certific y the attending p iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of deliv Month	ery Da y Year
w requires that been signed b should be deta			e, Vitamin B12	23e. Did tobacco use contribute to t	he cause of death?
	e Completed by	Ly per Cipliclenies · Refe 25. Was case referred to medical	urogethy by esophagetic	autopsy prior to co death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes	opsy findings available impletion of cause of 2 No
Phys	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Out 27. Manner of Death 1 ZNatural 5 Pending 2 Accident investigation Hospital: 1 Inpatient 2 EP/Out 28b. Till (Month, Day Year) In			(y)
5 5 th 6	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		f. Location (Street and Number or Rura City or Town, State)	,
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurred	at the time, date and place, and due to	o the cause(s)
		14 Robert Buschbream	29c. License number 0 4/15	29d. Date signed (Month, September 2	3,2005
		30. Name and address of person who completed cause of death (Item 3a) (The Complete Cause of Dea	ype, Print) XOI XUSSELL GAITHERS BU	41810UE 126, NO 20877	,
Si Regis	ate trar	SEP 2 8 2005	gode		

Amend #15 & 20b per FH 9/26/05 per AACO. Health Dept. lo

> **Physician** /Medical Examine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

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U	Ų	4	**	U

Funeral Director filed within 72 hours after death with the Maryland permil. Pages 1 and 2 should be filed within 72 hours atter death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23s or 28e-f ehow amportent: If Item 27 is marked other then "natural", or Items 23s or 28e-f ehow any injury or other treumatic event. The Medical Examination and once. Baltimore, Maryland 21215-0036

> Physician /Medical **Examiner** To the Hospitel or Attending Physicien; The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	- State Registrar				C	ertifica	ite of	Death	7		Reg	. No.	UJ	002	. 40
	1. Decedent's Name									2. Date of	_		V	3. Time o	of Death
	Florenc	e Hie	ber Rob	erts						Sept	. 2	O, 2	2005	8:00	м q (
Í	4a. Facility Name (If	not institution	, give street and n	um <i>ber)</i>		4b. Cit	y, Town, o	r Location	of Death				ity of Death		
	Anne Ar	undel	Medica	l Cent	er	1	Anr	napo	lis			An	ne A	runde	1
	5. Social Security Nu		6. Sex		s. last birthda		ter 1 Year	If Unde	r 24 Hrs.	8. Date of (Month,	Birth .			place (State untry)	
-	216-28-22	256	1 □ M 2 🛛 F	9	3 Yrs.	Month	s Days	Hours	Min.	July	27.	^{ear)} 1912	Cou	intry)	
İ	Usual Residence of I					1		1	-	0 0.27	/		*1		
	_	10b. County		10c. (City, Town or									10d. Inside C	City Limits
	MD	Anne	Arundel			Sev	erna	Park						1 🖺 Yes	2 NO
ŀ	10e. Street and Num	ber				10f. Z	Zip Code				10g	. Citizen o	f What Cou	intry?	-
	43 West 1	McKins	ey, Apt.	315		1	21	1146					US		
-	11. Marital Status			cedent Ever in	U.S. 1:	3. Was Dec			rigin? (Sp	ecify Yes or	No-	14. R	ace - Ameri		
	1 Never Marrie	d 2□ Marri	Armed F	orces? 2 X No		If Yes, sp	ecify Cuba	an, Mexica	an, Puerto	Rican, etc.)			lack, White		
-	3 XWidowed 4		If Yes, G Year or	ive		1 🗆 Yes	2⊠ No	Specify	<i>/</i> :			Spec	ity:	White	
		15. Decedent	t's Education		16a De	cedent's Us	sual Occur	nation			16	h Kind of	Business/Ir	ndustry	-
	(Specif	y only highes	st grade completed		(Gi	ve kind of v	vork done	during mo	st of work	ing	10	D. 7(IIIG OI	Dusinessyn	lidustry	
j	Elementary/Secon	dary (0-12)		(1-4or 5+)				_							
	17. Father's Name (F		last)			П	omema		ner's Name	e (First, Mide	dio Ma		lome		
	Arthur 1							_		Elizab			,		
					1.16.16										
	19a. Informant's Nar									al Route Nur			n, State, Zi	p Code)	
	Carol R		S/N1ece					all,		na Pa			21146		
	20a. Method of Dispo	Stremation	3 Removal from		Place of Dis cemetery, c	position (N rematory or	iame of r other plac	ce)	Sept	23,	20	c. Location	n - City or T	own, Slate	
	`4 □Donation				Metro	Crema	tory	į	_	2004	I	Balti	more,	MD	
	21. Signature of Fun	eral Service	Licensee				-					-	iorc,	neral	
	1 Aho	mJ	M.			495 G	OV b	i tch	S, P.	y, Se	veri	na Pa	rk fu	nera⊥ D 211	HOME 46
1	23a. Part1. Enter the	e disease, or	complications that	caused the de									TV' LI	Approxima	
	shock, or heart Immediate Cause (F	failure. List	only one cause on	each line.			-	-			•			Interval Be Onset and	
ı	disease or condition resulting in death)		_ a /L	190	13167	1/46	110	JA	14 0.	Tiar					
	rosalling in douting		Due to	(or as a cons	equence of):	-									
ĺ	Sequentially list con	ditions,	b	HOM		2/	ピル	05	ر ر						
	Sequentially list con if any, leading to immo cause. Enter Under	nediate lying	Due to	(or as a cons	equence of):										
	Cause (Disease or in that initiated events resulting in death) La	njury	c												
	resulting in death) to	151	Due to	o (or as a cons	equence of):										
			d												
	IF FEMALE: 23b. Was decedent	pregnant		utcome of preg		Cleatonia						23d. 0	Date of deliv	rery	
	in the past 12			gnant at time of		B∐Ectopic 5 ☐ Other (y 			_		Jonth	Day	Year
	9 □ Unknown	140	9□Unk	nown											
Ì	Part II. Other signific	cant condition	ons contributing to	death but not r	esulting in the	underlying	cause giv	en in Part	I.	23e. D	id tobac	co use co	ntribute to	the cause of	death?
										11	□Yes	2 No	3 ☐ Pro	bably 4 🗆	Unknown
										24a. W	itoosv	241	 Were auto prior to co 	opsy findings ompletion of o	available cause of
										1 \(\) Ye	rforme s 2	Z _i	death?	2□ No	
	25. Was case referre	ed to medical		2				26. Plac	e of Death	(Check on		-			
	examiner?	io	Hospital:	Inpatient 2	☐ ER/Outpat	ient 3 🗆 [OOA Oth	or		me 5□R		е 6 ПС	ther (Speci	fv)	
1	27. Manner of Death	_	28a. Date	e of Injury onth, Day Year)		of	28c. Injur	y at		28d. Describ				//	
J	Natural 2 ☐ Accident	5 Pendin investig		nun, Day Year)	Injun	М	Wor	rk? Yes 2.[No						
	3 🗌 Suicide	6 Could	not be 28e. Plac	ce of Injury - At	home, farm	street, facto				28f. Location	n (Stree	et and Nur	nber or Rur	al Route Nun	n <i>ber</i>
	4 🗌 Homicide	determ	buil	ding, etc. (Spe	city)		-7, 0000			City or	Town, S	State)			
-	20a Cartifica	Continue	a Dhusisiana Taut			-4h						4.5			
	29a. Certifier (Check only	2 Medicel	g Physicien: To the Exeminer: On the	basis of exami	nation and/or	investigation	on, in my o	me, date a pinion, de	ind place, ath occurr	and due to t ed at the tim	ne caus ne, dale	se(s) and i and place	nanner as s a, and due t	stated. to the cause(:	s)
	one)		and ma	nner stated.											
	29b. Signature and	THE OF CERTIFIE	\ //		0	2	9c. Licens		_	7	29d	Date sign		Day, Year)	
	P	sh	4 14	eun	2	-	1) 2	14	83	/	1 7	1/2	42	005	
	30. Name and addre	ss of person	who ompleted car	use of death (If	em 232 Typ	e, Print)						/	1		
			dy, M.D.,				, Anı	nami	is. N	/D 21	401				
	31. Date filed (Monti	h, Day, Year)	32.	Registrar's Sig	nature		, , , , , ,			<u> 21</u>	TUI				
r	SE	P 23	2005	Sugar.	K 1	mall	1								
		-													

Division of Vital Records, P.O. Box 68760.

ician	1. Decedent's Name (First, Middle, Last)	Pauror		2. Date of Death Month	1. No.2 0 0 5 3 3 1 Time of 4:3
dical niner	Earnest T. 4a. Facility Name (If not institution, give s		4b. City, Town, or Location	of Death	4c. County of Death
	Doctor's Commu	nity Hospital	Lanham		Prince George
al or	5. Social Security Number 6. Sex 1238-76-4902 Usual Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Year If Under 1 Year Months Days Hours	Min. (Month, Day, Y	9. Birthplace (State Country) 2 1948 North Ca
Director	10a. State 10b. County MD Prince Ge		wn or Location		10d. Inside C
	10e. Street and Number 10505 Meadow Lake	Terrace	10f. Zip Code 20721	100	D.S.A.
by Funeral		2. Was Decedent Ever in U.S. Amned Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexical	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	at of working	Sb. Kind of Business/Industry
	12th		Board of Educatio	n er's Name (First, Middle, Ma	Government
o Be	17. Father's Name (First, Middle, Last) Frank Moore			ulah Raynor	ilden Sumame)
	19a. Informant's Name/Relationship (Ty) Shirley Raynor/	TT 2 C	b. Mailing Address (Street and Number 0505 Meadow Lake		
once.	1 ■ Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complishock, or heart failure. List brily or	Ft.	Lincoln Ceme. 22. Name and Address of Facility 7474 Landover onot enter the mode of dying, such as	y J. B. Jen Road Landover	
ical Examiner	Sequentially list conditions, if any, reading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence			
Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day
þ	Part II. Other significant conditions con	tributing to death but not resulting f_{BPFICS}		1 Tes	cco use contribute to the cause of 2 Probably 4
Be Completed	25. Was case referred to medical				No 1 ☐ Yes 2 ☐ No
1.0	ayaminar?	lospital: 1 Alinpatient 2 ER/0	Othor	e of Death <i>(Check only one)</i> ursing Home 5 Residen	
ation: T	27. Manner of Death 1 KNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Time of Injury at Work? M 1 Yes 2	28d. Describe how	injury occurred
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		City or Town,	
20	29a. Certifier 1 Certifying Physical (Check only 2 Medical Examination)	sicien: To the best of my knowled ner: On the basis of examination and manner stated.	ge, death occurred at the time, date an and/or investigation, in my opinion, dea	nd place, and due to the cau ath occurred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause
dic			29c. License number	1000	d. Date signed (Month, Day, Year)
Medical Ce	29b. Signature and title of certifier		D C-OC 5 (Type, Print) eth Ave., Suite		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Dav Leander Ferguson Rucker 5:25 P.M. September 25, 2005 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FutureCare Pineview Nursing Home Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1922 9. Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕽 F 229-24-4100 82 Director November 2, Virginia Usual Residence of Decedent should be filed within 72 hours after deeth with the Marylend and Mantel Hygiene.
I marked other than "naturel", or items 23a or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Clinton 1 Yes 2 □ No Funeral Director ms 23a or 28e-fit 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane 20735 United States 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Š Specify: Black 3 Widowed 4 ☐ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Seamstress Department Stores other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 h end Mantel I Buford Thomas Ferguson Harriet Virginia Clayborne 1 4 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pages 1 end 2 s ment of Health er f Health (Vivian Eloise Smith (Daughter) 301 Dias Drive; Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dapartment of important: if It 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.1,2005 injury 4 ☐ Donation 5 ☐ Other (Specify) Williams Memorial Park Roanoke, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
W. Wesley Chavis III Funeral Services, Inc. any 1722 North Capitol Street, N.W.; Wash.D.C. 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) OSclerotic CAMO 10 Varular diagre Examiner Physician/Medical Examiner attending physicien and if or use as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 XNO 1 Yes 3 Probably 4 Unknown Š Be Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? has 21200 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Medical Certification: To Other: 1 Tes 200 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this eral Director: After thi filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1/2 Natural 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò within 24 hours a To the Funeral C Hoepita 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completaly 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 9 2005

			For State Registrar		State of	Maryla	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of He	alth and N <i>eath</i>	Mental Hy	/gien Reg. N		5 3	3246
72	Physici	3	1. Decedent's Name (F	irst, Middle, La	st)						2. Date of D Month	eath Da	av Vo		Time of Death
	Physici /Medic			Dorot		Rebecc	a R	amsbu	rg			ber	26 200	5 1.	1:20 P M
	Examir	er	4a. Facility Name (If no					4b. City, T	Town, or Lo	ocation of Death		4	c. County of D	eath	
			Frederick 5. Social Security Number				s. last birthday)	Fre	ederi	.ck If Under 24 Hrs.	O Data of D		Freder		
	Funeral Director		219-12-246		_M 21₹F		83 Yrs.	Months		Hours Min.	8. Date of Bi (Month, D Oct.	ay, Year L, 1		Bidhplace <i>Country)</i> aryla:	(State or Foreign nd
	and w	l	Usual Residence of De- 10a. State 10	b. County		100.0	City, Town or Lo	cation						1404.14	anida Oiballia
	Marylan f ehow	20	Maryland	,	ck		rederic								Yes 2 No
	or 28a-f	Director	10e. Street and Numbe				redefic	10f. Zip (Code			10a. C	itizen of What		Λ –
	23a o	O B	1900 Rosem	ont Ave	nue			2	1702			,	U.S.A	•	
	after deal	ner	11. Marital Status	37	12. Was Dece Armed For			Was Decede	ent of Hisp	anic Origin? (Sp Mexican, Puerto	ecify Yes or N	0-	14. Race - A Black, W		idian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland I of Health and Mental Hygiene. If item 27 ie marked other then "natural", or items 23a or 28a-f ehow or other treumatic event, the Modical Exacilizational Lancities.	Completed by Funeral	1 Never Married 3 Widowed 4		1 Tes If Yes, Give Year or Da	2 ∱ No 9		I ☐ Yes 2		Specify:	Tilodii, Sto.)			hite	
9	72 hours "natural", olcal Ext	ted	15.	. Decedent's E	ducation		16a. Dece	lent's Usual	Occupation	on		16b. l	Kind of Busine		,
21215-0036	within 7 ene. then "n	ple	(Specify of Elementary/Seconda	1	completed) College (1-	4or 5+)	(Give	kind of worl DO NOT use	k done dur e retired)	ing most of work	ang				,
	filed wi Hygien other th	Con	12				В	ısines	ss Own	ner		W	elding		
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	Be	John J. Rhe							8. Mother's Nam E11a V.			n Sumame)		
Z	should nd Men marka umatic	မ	19a. Informant's Name				19h Mailir	n Address		d Number or Rur			or Tours State	Zio Cod	-)
	and 2 seath ar n 27 to		William L.			(Husb	and) 3	01 Bra	addoc	k Avenu	e, Fred	erio	ck, Mar	yland	21703
re,	of Heal		20a. Method of Disposit				Place of Dispo				Date	20c. L	ocation - City	or Town, S	State
imo	Pa Int		1 🗗 Burial 2 □ C 4 □ Donation 5 □			Mt.	. Olive			9/30	/2005	Fred	lerick,	Mary	land
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny Injury or other tr ODGe.		21. Signature of Funera	al Sgrvice y Cel	Eller	A) 22 R 1	Name and OBERT 201 NO	Address of E. D.	of Facility AILEY & MARKET	SON, FU	NERA EDEE	T HOME	S, P.	A.
- 19 200	>9		23a. Part1. Enter the d shoot, or heart fa	ilsease, or com	plications that ca	tused the dea	ath. Do not ent	er the mode	of dying,	such as cardiac	or respiratory a	arrest,	CIOR, II	App	roximate rval Between
	Physician		Immediate Cause (Final disease or condition		, 5	ex!	ices	nia						Ons	et and Death
	/Medical Examiner		resulting in death)	•	Due to (c	or as a conse	equence of):	_	-					7 64 6	
		-	Sequentially list conditi	ions,	b. Due to (c	or a conse	allo	n j	ner	long	nia			20	up
	uted	Examiner	Sequentially list condition if any, leading to immediates. Enter Underlyin Cause (Disease or injustrat initiated events	ng 4			.44000 017.								
oʻ	sath certificate be executed ettending physicien and for use as the burial-transit	Еха	resulting in death) Last		Due to (c	or as a conse	equence of):								
68760,	ate be hysici	edical		•	d										
	ertifica ling pl		IF FEMALE:			2011-9									
Вох	eath certiff ettending for use as	lan/	23b. Was decedent pre	nths?		nth 2 ☐ Fe	tal death 3	Ectopic pre					23d. Date of o	delivery Day	Year
P.O.	the di	Physiclan/M	1 ☐ Yes 2 No 9 ☐ Unknown	0	9□ Unkno	ant at time of wn	death 5	Other (spe	city)					,	
	res that the igned by be detact	by Ph	Part II. Other significar	nt conditions	ontributing to de	ath but not re	sulting in the ur	derlying ca	use given i	in Part I.	23e. Did	tobacco	use contribute	to the car	use of death?
Records,	w requires been sign should be	ed b	Sever	nulli	-inx	and	dos	neni	ta,		10	Yes 2	× 100 3□	Probably	4 Unknown
000	e law requ hes been je 2 shouli	plet	huser	lension	1 1	Jehn	Soit	24			24a. Was		24b. Were	autopsy fi	ndings available
Ä	The ste he page	Completed	111			1	e de la contraction de la cont				auto perfe	psy ormed?	death		ion of cause of
of Vital	sicien: Th certificete rector, pag	Be (25. Was case referred examiner?	to medical					26	6. Place of Deat		one)	,		
) t	Shysi this c	ပ္	1 □ Yes ZXINO				ER/Outpatien			4 Nursing Ho				pecify)	
ou o	ding F h. After funera	Certification:		E Pending investigation		t Injury n, Day Year)	28b. Time of Injury	M 28	Work?	s 2 No	28d. Describe	how inju	iry occurred		
Division	Atten deat ctor: y the	flca		Could not b	Α	of Injury - At	home, farm, str				28f. Location (Street a	nd Number or	Rural Rou	ite Number
D	s after of Dire	Serti	4 Homicide	30101111100	buildin	g, etc. (Spec	aty)	,			City or To				
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete hi completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 2	Gertifying Ph Medical Exar	ysician: To the ininer: On the ba	sis of examir	nowledge, death nation and/or inv	occurred a restigation, i	t the time, in my opini	date and place, ion, death occurr	and due to the red at the time,	cause(s date an	i) and manner d place, and d	as stated.	cause(s)
	To the to the total company of	Σ	29b. Signature and title	of certifier	1.7.		1,1	29c.	License no	umber		29d. Da	ate signed (Mo	onth, Day,	Year)
•	1		ull	· CK	Klip	M	A	D	35	7/83		en	Senfe	en 2	7,2005
	a		30. Name and address	of person who	completed cause	of death (Ite	om 23a) (Type,	Print)	20	1.1 1	att	1	- 1	/	1,2005 MD
¥(c.	C+	10	31. Date filed (Month, D	Day-Year)	7/000	ogistrar's Sign	en //	10 -	200	west !	1177	1	reger	uk	(171)
	Sta Registr			SEP'2	2005	Colora .	J.S.	Spark.						-	
DH	MH 17 Bey 1/2	Sec.													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2005 12:10 AM Sept ne 24 ма /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis HealthCare -The Pines Easton Talbot If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F Days Sept. 29, 1927 218-20-4128 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant: if Item 27 is marked other then "natural", or Itams 23a or 28a-1 show Injury or other traumatic event, the Medical Examinar must be notified at 1 PYes 2 □ No Director MDaston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA Man's Lane 6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status UN Known Black, White, etc. hours after 1 Never Married 2 Married 0 1 ☐ Yes 212 No 21215-0036 Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene." Important: If Item 27 Is marked othar than " any Injury or other traumatic evant, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) stodian Office Building Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 99 Stanley ROZIER Lottie llen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7531-Wharfingen Ct. Glen Burnie, MD. 21061 Ann Sarah Thomas Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Mid Shore Crenation 128/05 Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME, P.A.
HENRY FUNERAL HOME, P.A.
COMBR. dge, permit. 21. Signature of Funeral Service Licensee 23a. Ph.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. MP. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year

3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify)

Month

6 ☐Other (Specify)

21 No

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

21601

de lying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the un

9 Unknown

2 ER/Outpatient

28b. Time of

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 1 TYes 2 No

2 No 1 Yes 26. Place of Death (Check only one) Other: Nursing Home 5 Residence

28d. Describe how injury occurred

1 ☐ Yes

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 No 1 Yes 27. Manner of Death

9 Unknown

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

þ

Completed

Be (

Certification: To

Medical

this certificate has I rat director, page 2 s

After

To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: Att

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ASTON

(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

29c. License number

29d. Date signed (Month, Day, Year) 26 65

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508

DANCHEE ROBERT 31 Date filed (Month. Year)

State Registrar

DHMH 17 Rev 1/2001

Thelma

P.O.

Division of Vital Records,

ORIGINAL

			1 - For Stata Registrar	State of Ma	aryland / [Departmer Certifica	nt of H	lealth a Death	ınd M		jiene	005	33248
	Diam'r		1. Decedent's Name (First, Middle, Last	t)		~- <u>-</u>				2. Date of Dea	th		3. Time of Death
	Physici /Medic		M	ary Theres	sa Rober	ts				OCTOBER	2 · 2	2005 ^{Year}	12:40 PM
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City	Town, o	r Location of	f Death		4c. C	ounty of Death	
			St. Mary's Hospi 5. Social Security Number 6. Se		(Im sum In at him		nard		DA Hrc			Mary'	
	Funeral Director			7. Age	78	Yrs. Months		Hours	Min.	8. Date of Birth (Month, Day May 9,	Year) 1927	9. Birth Cou Distri	place (State or Foreign ntry) Lct of Columb
	yland		10a. State 10b. County		10c. City, Town	n or Location							10d. Inside City Limits
	a-feh	tor	Maryland St. Mary's	S	Leonard	town							1 ☐ Yes 2XXNo
	ith the	Director	10e. Street and Number			10f. Zi	o Code			1	0g. Citize	n of What Cou	ntry?
	ath w		22650 Key Way			20	650				USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28s-1 ehow eny injury or other treumatic event, If the Maryland Example is unit to intermediate.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe	cify Cuba	ispanic Orig in, Mexican, Specity:	gin? (Spo Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Whit	etc.
Ş	2 hou	ed	15. Decedent's Edu		16a.	Decedent's Usu	al Occun	ation				of Business/In	
Maryland 21215-0036	hin 72	Completed	(Specify only highest grad	de completed) College (1-4or 5		(Give kind of wo	rk done d	durina most	of work	ing	TOD, KING	O Dusinessyni	dustry
7	ed with	Com	12			ales Cler	k				Pharm	acy	
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother	r's Name	e (First, Middle, i	Maiden Su	umame)	
<u> </u>	ould Men narke	2	Albert Jerome Hayden							a McGuire			
a N	12 st h and 7 is n treun		19a. Informant's Name/Relationship (T)							al Route Number			Code)
<u>ئ</u>	1 and Healt em 2	1	Theresa Ann Short / Da 20a. Method of Disposition	aughter	20b. Place of	Disposition (Na	me of	1		, Maryland Date		tion - City or To	our State
altimore,	ages ant of it: if it		1 X Burial 2 ☐ Cremation 3 ☐ F		cemeter	y, crematory or o	other plac	!	0ct	ober	200. L00a	mon - City or 10	own, state
₹	nit. Partme orten injur.		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		Charles	Memorial 22 Name a						dtown, Ma	aryland
ä	Dep Imp		Mucho Hour	Hunden	.\/					ral Home, n. Marylar		50	
	4-5		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. Do n								Approximate
	Physician		Immediate Cause (Final disease or condition		ESRD								Interval Between Onset and Death
	/Medical		resulting in death)	d	consequence of				*	1			
	Examiner		Sequentially list conditions,	b	Zesp	nati	2000	1 4	an	line	4		
	sit ed	lner	if any, leading to initivaliate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a	conseque ce c	of):	- (
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	·61.							
8760,	be es	a E			Consequence	J1 j.							
687	ficate physics the	edical		d									
Box	leath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							230	d. Date of delive	Arv.
o.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1□Live birth 4□Pregnant at 9□Unknown		3 □Ectopic p 5 □ Other (s _f						Month	Day Year
S,	es tha igned be del	oy P	Part II. Other significant conditions co	ntributing to death bu	it not resulting in	the underlying o	ause give	en in Part I.		23e. Did tob	acco use	contribute to th	ne cause of death?
ord	w require been si should b									1 □ Y€	s 2 🗆 l	No 3□Prob	ably 4 Donknown
Records,	e lawr has be je 2 sh	Completed								24a. Was a		24b. Were auto	psy findings available appletion of cause of
		Con								perform	ned?/	death?	2 No
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only on			
ot	d is	. To	1 ☐ Yes 2 € No 27. Manngr of Death	Hospital: 1 Impatier				7 (1101)		ne 5 Reside			1)
U _O	ting I. After fune	tion	Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of 2 njury M	28c. Injury Work	rat ⟨? Yes 2		28d. Describe ho	w injury o	ccurred	
Division	l or Attending Phatter death. Director: After the in by the funeral	fica	3 Suicide 6 Could not be	28e. Place of Inju	rv - At home, far			143 2 14		28f. Location (St	rest and N	lumber or Rum	I Route Number
	after s after t Dire	Certification:	4 Homicide	building, etc	. (Specify)	,	,,			City or Town		3772	Troute Hamber,
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	edical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best of iner: On the basis of and manner sta	examination and	, death occurred dor investigation	at the tim	ne, date and pinion, death	place, a	and due to the ca	use(s) an ate and pla	d manner as st ace, and due to	ated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1		29	c. License			25	d. Date s	igned (Month,	Day, Year)
)				1 mb			06	088	38.			10/0	3/05.
			30. Name and address of person wh	ted cause of de								1	*.
			DR. RAKHI KRISHNAN			CENTER	LEO	NARDT	OWN,	MD 206	88		
1	Sta	te	31. Date filed (Month Day Year) 4 2	NNS 32. Foistra	r's Signature	Land	,						

DHMH 17 Rev 1/2001

MARY THERESA ROBERTS

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar 33249 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Walter Albert Emil Rutter October 1, 2005 12:55 a.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Leonardtown

ar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) St. Mary's Nursing Center St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F Days Director 052-10-0313 84 April 15, 1921 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner hast be nutified at 1 Yes 2 No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 23196 Stoney Hill Lane death 20619 Funeral <u>United States</u> 'natural', or iteme 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ■Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Manufacturing 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 2008: Be 18. Mother's Name (First, Middle, Maiden Surname) Emil Rutter Amanda Bensler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William John Rutter / Son 25715 Vista Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdns 10-3-2005 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Carcinomatosis</u> Weeks /Medical Due to (or as a consequence of) Examiner Colon Cancer Sequentially list conditions, if any, bading to firm addate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Year Due to (or as a consequence of, Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 👺 No 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 ® Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injun s after de... М 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maliner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D06419 10-3-2005 ause of death (Item 23a) (Type, Print) 30. Name and address of person who completes J. Patrick M./D., 24035 Three Notch Road, Hollywood, Maryland 20636 Jarboe, th ردر strar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygien ? 115

		-	For State Registrar	State of Maryland	l / Depa <i>Cer</i>	irtment of H	ealth and Death		en 2005 g. No.	33250
	Physicia /Medic	_	1. Deepdent's Name (First, Middle, Last)	314110	2			2. Date of Death Month	95 300	3. Time of Death 10:55 RM
	Examin Funeral	er	4a, Facility Name (If not institution gives 5	treet and numbers. 7. Age (In yrs. Ia	KE st birthday)	JALIS If Under 1 Year	If Under 24 Hrs	. 8. Date of Birth	4c. County of Dea	thplace (State or Foreign
	Director		Usual Residence of Decedent	M 2□F 80	Yrs.	Months Days	Hours Min.	9/3/192		hington, DC
	e Marylar te-f ahow uffed at	Director	Maryland Wicomico		lisbu					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	ath w	8	5698 Bagpipe Court		10.1	218		Specific Veneral No.	USA 14. Race - Am	orican Indian
980	ors after de al', or Itam Examinar n	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U.S Armed Forces? 1	У	Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2 → No	Specify:	to Rican, etc.)	Black, Whi	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Madical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. i	dent's Usual Occupa kind of work done o DO NOT use retired Omist	luring most of wo	rking	6b. Kind of Business Financia	·
land 2	2 should be filed within 7 and Mental Hygiene. 7 is marked other than "raumatic event, the Mad	To Be Co	12 17. Father's Name (First, Middle, Last) Daniel R. Silling	g Sr.			18. Mother's Na Patsy E	me (First, Middle, M Barrett	laiden Sumame)	
Maryland	nd 2 shou alth and M 27 is mai r trauma		19a. Informant's Name/Relationship (Type R. Kelley Silling			-			City or Town, State, MD 2180	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crer	sition (Name of natory or other place y Cremato			oc. Location - City of Salisbury,	
Balti	permit. Departm Departm Importer any inju		21. Signature of Funeral Service Light		22 F	Name and Addres	s of Facility uneral	Home Prof	essional A	Association 304
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. le cause on each line. Lung Due to (or as a consequence of the consequence	ance	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death Month
100	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):					
8760,	ate be executed physicien and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequent.	ence of):					
Box 6	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
rds, P.O.	w requires that the been signed by th should be detache		Part II. Other significant conditions cor	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did tob		o the cause of death?
of Vital Record	The law ate hes b page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	tospital: 🗸		Othe		ath Check only one	a)	
of	S S	5 T	1 ☐ Yes 25 No 27. Manner of Death	1 atient 2 E	R/Outpatier 28b. Time o		4 🔲 Nursing	Home 5 Reside	nce 6 Other (Spi	ecify)
on	Attending or death.	tion	Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □No			
Division	E E te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, sti	reet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	lural Route Number,
	he Hospital in 24 hours s he Funeral I pletely filled	edical		ner: On the best of my know ner: On the basis of examinati and manner stated		vestigation, in my of	pinion, death occ	urred at the time, da	ite and place, and du	e to the cause(s)
	To the twithin 24 To the formplete	W	29b. Signature and title of certifier	bell n	1	29c. License	a number	78	9d. Date signed (Mor	sth, Day, Year) S-OS
-	7/3		30. Name and address of person who co DAMD COUALL, MD	completed cause of death (Item	23a) (Type,	Print) P.O. Bu	x /233	Sali	sbury 1	11, Day, Year) 15-05 11D 21802
100	Sta	ate	31. Date filed (Month Pay Year) 9 21	32. egistrar's Signat	ure	(v .			//	

		•	For State	State of Maryland / De	epartment of Health and I Certificate of Death	Mental Hygier		
	3		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death	
	Physicia		BESSIE I	BEATRICE .	2mith	Month 9	95 05 0830 M	
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	1	4c. County of Death	
	LAGIIII		Peninsula RegioNol	Medical Center	5145WM		HICIMICO	
	Funeral		Social Security Number 6. Sex		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birthplace (State or Foreign Country)	
	Director		110-14-5561	M 2004 817 Yr	S.	12-19	1917 MD	
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City. Town o	or Location		10d. Inside City Limits	
	eho	'n	MD Worce				1 XYes 2 □ No	
	28a-f	ect	10e. Street and Number	31017 100	O MOKE	10a.	Citizen of What Country?	
	with with	흐	514 Young.	T2	21851		A211	
	hours after death with the Maryland lurel', or Itams 23e or 28e-f ehow al Examinat must be rediffed at	Funeral Director		2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,	
"	fter d r Itan liner	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.	
036	urs a	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ■ No Specify:		Specify: Black	
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		ecedent's Usual Occupation Give kind of work done during most of wor	king 16b	. Kind of Business/Industry	
21	within one one one one one one one one one on	ng l	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)		amphell Soup Co.	
	filed withi Hygiene. Sther than	S	Coth		Laborer			
pu	Mental Mental arked c	To Be	17 Father's Name (First, Middle, Last)		SI)	ne (First, Middle, Maic	k	
yla				in n	Mailing Address (Street and Number or Ru	CO III C	true Town State Zin Code)	
Maryland	12 sho h and 7 is mu treum		19a. Informant's Name/Relationship (Ty)		110 0-	1	A- 10-17	
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date 200	. Location - City or Town, State	
ية	0 0		1 Burial 2 ☐ Cremation 3 ☐ R	cemetery,	n Neck Cemetry 10.	(1)-05	Zanach MD	
Baltimore	그 된 원 승 .		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		22 Name and Address of Facility		Ocomoke, MP	
Ba	Depa Impo any i		# 77	5/1000	Anthony, E. War	D Funeral	USS LANG MD 3-1853	
			23a. Part1. Enter the disease, or compli	cations that caused the death. Do no	t enter the mode of dying, such as cardiac		Approximate Interval Between	
150	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	unota Carpoio			
			disease or condition resulting in death)	Due to (or as a consequence of		inuico e	-13.euc	
	Examiner							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	cuted	Examln	that initiated events					
oʻ	e exe ian ai urial-t		resulting in death) Last	Due to (or as a consequence of) :			
8760,	ate be executed thysician and the burial-transit	Ica						
9	leath certifica attending ph i for use as th	Mec	IF FEMALE:	0. 16				
Вох	ath cuttend	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year	
	ing Physician: The taw requires that the dr. t. After this certificate has been signed by the funeral director, page 2 should be detached	Certification: To Be Completed by Physician/Medical	1 Yes 2 No	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown				
Records, P.O.			Part II. Other significant conditions cor	tributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
			ConoNamy- A	eting Disean	-	1 Yes	2 No 3 Probably 4 Unknown	
			RANAL Failu	211		24a. Was an	24b. Were autopsy findings available	
Re			Typone / area	10		autopsy performed	prior to completion of cause of death?	
Division of Vital			25. Was case referred to medical	Esqui	26 Place of De	1 ☐ Yes 2. Ath (Check only one)	No 1 ☐ Yes 2 ☐ No	
			examiner?	ospital: 1 Inpatient 2 ER/Outp	Other		e 6 □Other (Specify)	
			27. Manner of Death	28a. Date of Injury 28b. Tir		28d. Describe how in		
			1 Natural 5 Pending 2 Accident investigation	(Wohl, Day (ear)	M 1 Yes 2 No			
vis	Atte er de ecto by th	E C	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
ā	telor rs afte at Dir	Ce		3, , , , ,				
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the it	edical	(Check only 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and/	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	a(s) and manner as stated. and place, and due to the cause(s)	
	the thin 2 the mplet	Med	one)	and manner stated.	29c License number	294	Date signed (Month, Day, Year)	
	To To		29b. Signature and title of certifier	44.0	D24872	[A	1-1-	
,			30. Name and address of person who	M.O	y - 70/	7,	125/03	
			PAUL R FLEUR	Inpleted cause of death (item 23a) (1	Th ST POCOMO	DICE City	M-D	
3.5	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registi		SEP 2 8	2006 Blow &	29c. License number D 2 4872 ype, Print) Th ST Pocom C			

State of Maryland / Department of Health and Mental Hygiene. For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Da **Physician** 5:00 A. M Ethel Furstman Schwarz September 27, 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year 1 ☐ M 2 🗓 F New Jersey 89 1916 Director 075-12-0709 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State "natural", or Items 23a or 28e-f ehow ntal Hygiene. od other than "natural", or Items 23s or 28e-f ehov event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director New Jersey Morris Ledgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 07852 4 Loch Lane United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene Important; or Itel Important; if item 27 is marked other than "natural", or Itel and yinjury or other traumatic event, the Madical Examinan and yinjury or other traumatic event, the Madical Examinations. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Furstman Celia Levy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9311 Friars Road, Bethesda, Maryland 20817 Claudia Feldman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 29, 2005 Dover, New Jersey Mt. Sinai Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Franeral Service Licensee M01353 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physicion: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy ō Day 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 🗍 Unknown 1 🗌 Yes peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural after death. Director: Af 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No the 1 6 Could not be determined 3 ☐ Suicide l in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) amora 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) oms 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 Registrar

			For State Registrar	State of	Marylan		artment of F		Mental Hy	giene Reg. No. 2	005	33253
			1. Decedent's Name (First, Middle	, Last)			<u>.</u>		2. Date of De			3. Time of Death
	Physicia	_	JOHN B	LMBR	SMI	T14			Month OY -	Day -	Year	07:10 AM
,	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of De	ath	4c. Cou	nty of Death	
	LAGITIM	-	Deer's Head	Center			Salis	sbury		Wic	omico)
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th Vear	9. Birthp	lace (State or Foreign
	Director		218-12-1122	1 M 2□F	87	Yrs.	Months Days	Hours M	sept.1	8 191	8 Mary	lace (State or Foreign Tland
	ס	ļ	Usual Residence of Decedent									
	ylan how	.	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Ma-f-	ë	Maryland Wic	omico		Salis	sbury					1 Tyes 2 No
	h the	Directo	10e. Street and Number	-			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	11 wi	al	169 Capitola	Road			2186	55		U.S.	A	
	n 72 hours after death with the Marylan *natural; or items 23e or 28a-f ehow edical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. F	Race - Americ Black, White,	
٥	or it		1 Never Married 2 Marr		No		1 ☐ Yes 2 KNo	Specify:			-14	
3	ours	d by	3 Widowed 4 Divorced	Year or Dat	es:						BTS	
ፈ	72 h	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of v	vorking	16b. Kind of	f Business/In	dustry
7	rithin ne. ne.	d l	Elementary/Secondary (0-12)	College (1-4	4or 5+)					NT		
7	ygier ygier ti.		6			Truc	ck Drive		lame (First, Middle,		ne	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Brited other than "natural", or items 23e or 28e-f ehow attic event, the Medical Evaruhen metal be routified at	Be	17. Father's Name (First, Middle,								таттө)	
<u>\{ \} \</u>	should by	ပ္	William Smit						stina Ha			
Maryland 21215-0036	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations						Rural Route Numbe			Code)
	and lealth m 27 her t		Douglas A.Mos	25 (5011)	20h 5		A11-00		Seaford		on - City or To	uun Stata
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal from S			sition (Name of matory or other pla	ce)	4 05			
Ξ	Pages ment of tant: If it		'4 □Donation 5 □Other (S	oecify)	wn	rtenav	en Cem.	. 10-	-1-05	Tyask	in,Md	•
<u></u>	epart poort y in		21. Signature of Funeral Service	_icensee	1		Stewarter					
m	20229	0 4	Bladys	3, Stewn	ers				alisbury		1801	
Ε.			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the deat ch line.	h. Do not en	ter the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	END	5.7	ACR	RRN	1-1-	DRIBA	5%	-	Onset and Death
	/Medical		resulting in death)	Due to jo	r as a conseq	uence of):			DASA			
	Examiner		Competially list conditions	b. D/1	413R	TBS	MEL	LITUS				10 YEARS.
11.2		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a	r as a curiseo	points of).						
	e be executed rsician and e burial-transit	Examin	that initiated events	c								
Ó	e exe ian a urial-	Ĕ	resulting in death) Last	Due to (o	ras a consec	juence of):						
8760	# 54	dlcal		d						·		
9	ntiffica ng pl	Wed	IF FEMALE:									- 2
Š	eath certific attending p I for use as	an/l	23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 □ Fete	ancy el death 3[Ectopic pregnanc	у			Date of delive Month	ery Day Year
B	0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	nt at time of c	leath 5	Other (specify)				WOHAT	Day 10a1
о. О	at the de by the	Physician/Me	9 Unknown									
ś	The law requires that the tite has been signed by thoage 2 should be detache	by	Part II. Other significant condition	ins contributing to dea	ath but not res	sulting in the u	inderlying cause giv	en in Part I.				ne cause of death?
Record	v require been sig should b	ed						-	_ 10`	Yes 2 No	3 Prob	ably 4 Unknown
ပ္ထ	has be	ple							24a. Was	an 24	b. Were auto	psy findings available impletion of cause of
	The late has page	Completed							perfo	rmed? 22 No	death? 1 🔲 Yes	2 No
Vital	ilcien: Th certificate rector, pag	0	25. Was case referred to medica	-				26. Place of C	Death (Check only o	one)		
	S 5	To B	examiner?	Hospital: 1 ☐ In	patient 2	ER/Outpatie	nt 3 DOA Oth	ner: 4 Voursing	g Home 5 ☐ Resid	dence 6 🗆 0	Other (Specif	y)
Division of	g Ph ier th heral		27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time o	f 28c. inju		28d. Describe			
O	ttending F death. ctor: After y the funer	ato	1 Natural 5 Pendir 2 Accident investi	9	, Day 1041/	injury		Yes 2 □ No				
<u>N</u>	or Attenation	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Place	of Injury - At h		reet, factory, office		28f. Location (S		ımber or Rura	l Route Number,
Ö	al or A s after i Dire	Certification:	4 - Nomicido	buildin	g, etc. (apecin	7/			0.1, 0.7			
	Hospital 4 hours Funerel tely filled		29a. Certifier 1 Certifyir	g Physician: To the	pest of my kno	owledge, deat	h occurred at the ti	me, date and pla	ace, and due to the	cause(s) and	manner as s	ated.
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical one)	Examiner: On the ba		ation and/or in	ivestigation, in my o	ppinion, death of	courred at the time,	date and plac	ce, and due to	ne cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifie	r			29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
	/		1	er 1-	~		.1)0	0584	10	4/	25/)
	1/2		30. Name and address of person	who completed cause	of death (Iter	п 23а) (Туре,	Print)					
	da		GHULAM	WARIS	262	66 /	ARROW	wich	CT.	57	72/313	(My mp 2120)
	Sta	ite	31. Date filed (Month SEP 22)	8 2005 32.	gistrar's Sign	ature						
	Regist		ULF A	O ZUUDI 🥂		H.	/					

			1 - For State Registrar		State o	of Marylan		artment of tificate of			lental Hy	giens	2111	05	33254
	Physic /Medi		1. Decedent's Nam	ne (First, Middle	Robert (C. Stone)				2. Date of Do Month Septen	eath Da	у	Year 2005	3. Time of Death 3:10 P. M
	Exami		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town,	or Location	of Death	Борса			of Death	J.10 F.
		Ŀ			escent Ce			Croft				A	nne	Arund	del
	Funeral Director		5. Social Security N 723-05-6	6305	6. Sex 13€ M 2 ☐ F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bi (Month, Di NOV • 2	rth av, Year) 7, 1	913	9. Birthp Coun Penns	lace (State or Foreign stry) Sylvania
	land		Usual Residence o	10b. County		10c. Cit	y, Town or Lo	cation							0d. Inside City Limits
	Mary I-f sh	ţo	PA.	Alleg	heny		C	oraopoli	.S						1 ∰Yes 2 ☐ No
	or 289	irec	10e. Street and Nu		•			10f. Zip Code				10g. Cit	tizen of \	What Coun	try?
	23e c	ai	1102 Hi	land Av	enue				15108			U	SA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If items 27 is marked other then "naturel", or Items 23e or 28a-f show or other treumatic event, the Medical Examination in stilled at	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed		ed 1224 es If Yes, Gir	2 🗆 No	J:	Vas Decedent of Yes, specify Cu ☐ Yes 2€ No	ban, Mexica	an, Puerto	ecify Yes or No Rican, etc.))-	Blac	e - America ck. White. e	etc.
9	2 hou	pa	- Z masiisa	15. Decedent		ates. WWTT	16a, Deced	lent's Usuai Occi	ination			16b K	ind of Ru	usiness/Ind	histor
215	hin 72	plet	(Spec	cify only highes	t grade completed) College (1-40r 5+\	(Give	kind of work don OO NOT use retir	e durina mo	st of worki	ng	100. K	ind of Bu	12111622/1110	lustry
21215-0036	filed within Hygiene. ther then "	Completed	Liomontary	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	1-401 5+)	Sa	alesman				Ma	nufa	cturi	ing
Maryland	should be file nd Mental Hy marked oth matic event	To Be (17. Father's Name	(First, Middle, L	Carleton	Elijah	Stone		18. Moth		(First, Middle 21 Robi			10)	
Man	2 sho and is me		19a. Informant's N	ame/Relationsh	nip (Type, Print)			g Address (Stree							
	1 and Health em 27 ther tr				a – daugh			Orangew							
Baltimore,	nit. Pages I hartment of It ortent: If ite injury or ot g.		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 ⊠Removal from pecify)	Otato		sition (Name of patory or other platory or other platory	1		8/05			City or Tov	
Ball	permit. Page Department (Importent: If eny injury or		21. Signature of Fu	ineral Servide L	icensee V	Bealf	į .	Name and Addr		ity Bea	all Fur	eral	Hor	ne	
г			23a, Part1, Enter t shock, or hea	he disease, or out failure. List o	complications that conly one cause on e	aused the death ach line.	Do not ente	or the mode of dy	ing, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause	(Final on	_a. (07+	Roma	sula	v acc	eden	F					Onset and Death
	/Medical Examiner		resulting in death)		Due to	or as a consequ	uence of):								7113
		i i	Sequentially list co	nditions.	b. ————————————————————————————————————	or as a consequ	uence of):								
	uted d ansit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	injury			•								
0,	an an rial-tr	Exa	resulting in death) I	Last	Due to	or as a consequ	uence of):								
68760,	ificate be executed g physician and as the burial-transit	edical			d										
	- D 03	Med	IF FEMALE:												
.О. Вох	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	Physiclan/M	23b. Was decedent in the past 12 1 Yes 2 5 Unknown	months?	1 Live b	come of pregnal irth 2 Fetal ant at time of de own	death 3□	Ectopic pregnand Other (s <i>pecify)</i> _	Б У			4	23d. Date Mor	e of deliver oth [y Day Year
s, P	es that igned b	by PI	Part II. Other signif	icant condition	ns contributing to de	eath but not resu	ılting in the un	derlying cause g	ven in Part	1.	23e. Did to	орассо п	se contr	ibute to the	cause of death?
rds	w require been sig should b	edk	La zare	dus	reles,	Hu per	Terseon				101	res 2 f	No	3 🗌 Proba	bly 4 Unknown
of Vital Record	e law requ has been je 2 shoul	Completed									24a. Was		24b. W	Vere autop:	sy findings available
<u> </u>		Com										rmed? 2 ₩ No	d	eath?	pletion of cause of
/iita	icien: Th certificate rector. pag	Be (25. Was case reference examiner?	red to medical	11					of Death	(Check only o				
of	Phys this al dii	-T	1 Yes 2 2				ER/Outpatient	3 DOA			ne 5 Resid				
		ton	1 Natural	5 Pending		h, Day Year)	28b. Time of Injury	28c. Inju Wo	iryat ork?]Yes 2. □		8d. Describe h	now injury	occurre	∍d	
Division	al or Attendii atter death. I Director: Al d in by the fu	ertiflcation;	2 Accident 3 Suicide	6 Could no	ot be	of Injury - At hor	me, farm, stre	et, factory, office			8f Location (S	Street and	1 Numba	or or Rural	Route Number,
Ö	al or safter	Certi	4 Homicide	determin	buildir	ng, etc. (Specify,)	ot, ractory, omoo			City or Ton	m, State))	, or ribrar	riodie ivaliiber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier (Check only one)	10 Certifying 2 Medical E	Physician: To the xaminer: On the ba	isis of examinati	wledge, death ion and/or inve	occurred at the ti estigation, in my	ime, date ar opinion, dea	id place, a ith occurre	nd due to the o	cause(s) date and	and mar place, a	nner as star nd due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of conting				29c. Licens	se number			29d. Date	signed	(Month, Da	ay, Year)
	14			AUN.	^	SA		DOC	38%	58		7/2	80/	05	
10	U		30. Name and addre		no completed cause	e of death (Item	23a) (Type, P	rint)				. / 0	-/-		
			Daljee		INGH	SIDIH	u 21	08 CrA	114/	twy	5W1	Fler	1 Bi	mie,	MD 21061
	Sta Registi		SEP 3 0	2005		egistrar's Signati	ure							,	

ORIGINAL

	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland	/ Department Certificate			Reg. No.	3 3 2 5 5
Physician /Medical	Stephe 4a. Facility Name (If not institution, give s		encer	own, or Location of Death	Septemb	er 17, 2005 4c. County of Death	4:37 P.
Examiner Funeral Director	Holy Cross Hospi 5. Social Security Number 6. Sex	tal	t birthday) If Under 1	ilver Spring Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir	Montgome th y, Year) 9. Birth Cor 0, 1949 New	place (State or Foreig
,	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	C	Town or Location				10d. Inside City Limit
or 26 be no			10f. Zip (10g. Citizen of What Co	
ar, or its	3 ☐ Widowed 4 X Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		20902 ant of Hispanic Origin? (Sity Cuban, Mexican, Puerto		Specify: B	rican Indian, e, etc. Lack
tal Hyglene. d other than "naturnevent, the Medical event, the Medical Be Completed	15. Decedent's Edu (Specify only highest grade			c done during most of wor e retired) ns Manager		Greyston Ba	
even Be	17. Father's Name (First, Middle, Last) Stanley Spe	ncer		Ethel	Mae	, Maiden Surname) Shelton	
la ma	19a. Informant's Name/Relationship (Ty						
Health am 27 ther tr	Bianca Adoni Whit 20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State Ches	ce of Disposition (Nam netery, crematory or ot	arose Drive; of her place) Sept ematory, Inc	. ^{Date} 4,200	ilver Sprin 5 ^{20c. Location · City or} Beltsville	Town, State
Department of P Important: If ite any Injury or o once.	21. Signature of Funeral Sphile Licens	3. Anila	600 Ke	ennedy Stree	t, N. W.;	ticians, ING Washington,	D.C. 200
ysician Medical	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications'that caused the death. ne cause on each line. a	y Failure	of dying, such as cardiac	or respiratory a	irrest,	Approximate Interval Between Onset and Death
aminer		Due to (or as a conseque					181
physician and is the burial-transit	resulting in death) Last	Sepsis Due to (or as a conseque Infected P					
or use as		23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 ☐ Ectopic pre			23d. Date of del Month	ivery Day Year
be d	Part II, Other significant conditions co	-	ting in the underlying ca	ause given in Part I.		tobacco use contribute to Yes 2 X No 3 ☐ Pr	
page 2 should to	Chronic Renal E	'ailure			24a. Was auto perf	opsy prior to ormed? prior to death?	stopsy findings available completion of cause
certificate har rector, page				26 Place of De	1 ☐ Yes ath (Check only		2 No
ihis I	examiner? 1 Yes 2 No		R/Outpatient 3 DO 28b. Time of lnjury M	Out	lome 5□Res	idence 6 Other (Spe	city)
		28e. Place of Injury - At hom building, etc. (Specify)			City or To	(Street and Number or Ri wn, State)	
24 hour	29a. Certifier 1X Certifying Phy (Check only 2 Medical Examone)	vsician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death occurred on and/or investigation.	at the time, date and place, in my opinion, death occ	e, and due to the urred at the time	, date and place, and due	to the cause(s)
within 2 To the complet	29b. Signature and title Certifier		290	License number 47876		29d. Date signed (Mont September 1	
State	Oncy / Zuniga 31. Date filed (Month, Day, Year)	omplated cause of death (Item I.D.; 4701 Rand 2. Registrar's Signatu	olph Road;	Suite 101;	Rockvil	le, Marylan	d 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

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3	3	2	5	r

			1 - State Registrer		Cei	tificate of	Death		Reg. N			00200
			Decedent's Name (First, Middle, La.	st)				2. Date of D	eath			3. Time of Death
	Physic		John Wil	Lliam Snowden				Sept.		ау 2005	ar	11:22A M
	/Medi Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea		-	c. County of D	eath	11.22A
			Washington Advent	ist Hospital		Takoma	Park		N	lontgom	erv	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of B	irth	0	Birthpla	ice (State or Foreign
į.	Director		220-28-5707 Usual Residence of Decedent	⊠ ^{M 2□F} 72	Yrs.	Months Days	Hours Min	Jan. 1	3, 1	933 Wa	countr ash,	D.C.
	ylan		10a. State 10b. County	10c. C	ity, Town or Lo	cation					100	d. Inside City Limits
	B-fs	cto	Maryland Prince (George L	andovei	Hills						1⊠Yes 2□No
	3a or 28	Funeral Director	10e. Street and Number 4108-72 Avenue			10f. Zip Code	20784			itizen of What		,
	ms 2	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of H f Yes, specify Cuba				14. Race - A		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show apprintury or other traumatic event, I'm Medical Examilier must be notified at ance.	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		f Yes, specify Cuba I□Yes 218 No	n, Mexican, Puèr Specify:	to Rican, etc.)		Black, W Specify: I	hite, et	c.
2000	ain 72 ha In "natu Mazileai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of wo	rking	16b. l	Kind of Busine	ss/Indu	stry
i	d with giene ir tha	E O	8th	College (1-40r 5+)	Driv	ver			P	rivate		
	othe vent,	- O	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maide	n Sumame)		
	Menta Menta arked aric en	To B	John W. Snowder	1			Helen	Wilson				
, mar y laring	and 2 sho raith and 1 27 is mu er traume		19a. Informant's Name/Relationship (Rhoda Snowden/Sp	,, ,		g Address <i>(Street a</i> 72 Ave. I				or Town, State 20784		code)
	Pages 1: nent of He int: If iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cren	sition (Name of natory or other plac n Nationa	1	Date . 30,2005		ocation - City		
3	permit. Departrimporta any inju		21. Signature of Funeral Service Lice	1 11		. Name and Addres		ope Fun 538 Mar orestvi			-	
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the dea	th. Do not ente	er the mode of dying	g, such as cardia	c or respiratory a	arrest.	rib.		Approximate nterval Between
	hysician		Immediate Cause (Final								lr C	nterval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. METASTA Due to (or as a consec	TIC C	ARCINOM	A LIL	JG			+	14
	Examiner			b. DIABETE	. ,		r					1
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	AELL IV						725
	cuted nd ransit	Examiner	that initiated events	C.								
9	certificate be executed Iding physician and ise as the burial-transit		resulting in death) Last	Due to (or as a consec	uence of):							
	tificate b ig physic as the b	lica		d								
	ding p	/Medicai	IF FEMALE:									
	The faw requires that the death or tite has been signed by the attend bage 2 should be detached for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms.	aldeath 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of o Month	delivery Da	ay Year
	that I led by deta		Part II. Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause give	n in Part I.	23e. Did 1	tobacco	use contribute	to the	cause of death?
	w requires been sign should be	ted by										ly 4 ⊠ Unknown
		Completed						24a. Was auto perfo 1 \sum Yes	psy ormed?	prior t death	o como	y findings available letion of cause of
1	kician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					th (Check only	one)_			
	Physi rthis c ral dire	은	I Les ZANO	Hospital: 1 Inpatient 2	ER/Outpatient		4 Li italianing ti	lome 5 Resi	dence	6 □Other (S)	oecify)	
	Attending P death. ctor: After I y the funera	ation:	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 1	at ? ′es 2 □ No	28d. Describe	how inju	ry occurred		
	al or Attanos safter death Il Director: id in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre y)	et, factory, office		28f. Location (City or To	Street al wn, State	nd Number or . e)	Rural R	loute Number,
	To the Hospital or Attending Physician: within 24 hours atten death. To the Funeral Director: After this certified completely filled in by the funeral director, it	edical (29a. Certifier 1 X Certifying Phyone) 2 Medicel Exem	ysicien: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ition and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and manner d place, and d	as state	ed. e cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	- 1	29d. Da	te signed (Mo	nth, Da	y, Year)
			M.S. No	ye -		D -	1787-	4		1-26		
1	(7)		30. Name and address of person who c	completed cause of death (Item	n 23a) (Type, F	Print)						
-	C.		31. Date filed (Month, Day, Year)	Panietrarie Ciana	- 2 Z.	TIVE, DI	CE 14 100					
	Sta Registr	-	SFP 2 9 2005	2. Registrar's Signa	Board	e e						

		•	For State Registrar	State of	of Maryla	and / Depa <i>Cel</i>	artment of H	lealth and Death	Mental Hy	giene Reg. No.	2005	33257
	Dhysiai	20	1. Decedent's Name (First, Middle	e, Last)					2. Date of Do		Vear	3. Time of Death
	Physici /Medic		Alease Scott						09	27	2005 ^{ear}	9:37 A.M
	Examin		0320 2 0211022	n, give street and nu Avenue	mber)		4b. City, Town, or OXON Hi	11			County of Death	orges County
	Funeral Director		5. Social Security Number 223–16–2008	6. Sex 1 ☐ M 2 X F	7. Age (In y 95	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		1909	9. Birthp Virg	lace (State or Foreign inia
	Maryland -1 show lied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Princ	e Georges	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	h with the 23a or 28s	ai Direc	10e. Street and Number 6910 Furness	Avenue			10f. Zip Code 20745			10g. Citiz USA	zen of What Cour	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	If Voc G	orces? 2∭No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or Netro Rican, etc.)		14. Race - Americ Black, White, Specify: Bla	etc.
21215-0036	within 72 ho ene. than "natur is Wedical	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 10th grade	t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired PRENEUR	during most of v	vorking		nd of Business/Ind vate	dustry
and 2	d be filed vental Hygie	To Be Co	17. Father's Name (First, Middle, Richard Turne)	-					lame (First, Middle	, Maiden	Sumame)	
Maryland	nd 2 shoul aith and Me 27 is marl r traumati	Ě	19a. Informant's Name/Relations Hazel Byrdsong/			19b. Mailir 6910	ng Address (Street a	and Number or	Rural Route Numb	er, City or	Town, State, Zip	Code)
Baltimore,	it. Pages 1 a rtment of Hea rtant: If Item njury or othe		20a. Method of Disposition 1. Surral 2 Cremation 4 Donation 5 Other (S	3 □Removal from		Forest I	sition (Name of matory or other place Lawn Ceme? 2. Name and Address	tery 10	Date -01-05	Empo	cation-City or To oria, VA neval Ser	
Ba	perm Depe Impo any i		Care N.	Struc	Kle	20 6	500 Allen	town Rd	. Camp S	pring		748
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Ath	each line.	lerosic	Cardia (7.5	Approximate Interval Between Onset and Death
	5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a cons	sequence of):						
38760,	icate be executed physicien and s the burial-transit	dicai Exa	resulting in death) Last	Due to	(or as a cons	sequence of);						
P.O. Box 6	death certifie attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 □ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ry Day Year
	law requires that the as been signed by th 2 should be detacht	by	Part II. Other significant condition	ons contributing to d	eath but not	resulting in the u	nderlying cause give	en in Part I.		tobacco us Yes 2		e cause of death? ably 4 Duknown
I Records,	The ate h page	Completed							24a. Was auto perfo 1 Yes	psy orm ad ?		psy findings available inpletion of cause of
of Vital	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medica examiner?						eath (Check only	one)		
of	Physi this c	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 28a. Date		ER/Outpatien		4 🗀 Nursing	Home 5 Resi)
no	Jing Afte fune	tion	1-☐Natural 5 ☐ Pendir	ig (Mor	th, Day Year		Worl	γaτ <br Yes 2 □ No	28d. Describe	now injury	occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Certification;	2 Accident Investig	not be 28e. Place	of Injury - A ing, etc. (Spe	t home, farm, str acify)	eet, factory, office	.00 2	28f. Location (City or To		Number or Rura	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b.	Medical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my leasis of examiner stated.	knowledge, death ination and/or in	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) a	and manner as st place, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Ň	29b. Signature and title of certifie	r			29c. License			29d. Date	signed (Month, L	
}			1 mgil				04	5365			09-00	28-2021
R	(5)			arous, 11	se of death (I	tem 23a) (Type,	Print) N/ 4/01	fi ins	hington	m	20742	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2		Registrar's Sig	gnature Spa	de					

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of Mar		Departme Certifica						005	33258
	Physici /Medic		Fauvette Wisha	rd Smith						Month October	Day 5	2005	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, give Washington County			4b. Ci		erstow				ashing	ton
	Funeral Director		5. Social Security Number 6. Se 162-22-0905	7. Age ('In yrs. last bin	Yrs. If Und Month	er 1 Year s Days	If Under 24 H	lin.	8. Date of Birth (Month, Day,) Sept. 13,		Coul	
	faryland show	or	10a. State 10b. County Md. Washin		Oc. City, Town	or Location Smiths	burg					1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-	rect	10e. Street and Number				ip Code			100	. Citizen	of What Cour	
	3a or	0	13113 Greensburg F	d.			21	783				U.S.A	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show sary flutry or other traumatic event, the Medical Examination and Anne Anne Anne. 2016.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:			edent of His ecity Cuban 2 1100	panic Origin? , Mexican, Pi Specify:	(Specuento R	cify Yes or No- lican, etc.)	E	Race - Americ Black, White,	can Indian,
21215-0036	within 72 ho ane. then "natur te Medical i	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le <i>completed)</i> College (1-4or 5+)		Decedent's Us (Give kind of v life. DO NOT Manager	vork done du use retired)	uring most of		9	6b. Kind o	f Business/in	
Maryland 2	buld be filed Mental Hygi arked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last) Morris Toms						Мо	(First, Middle, Ma	yor		
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (T) Danny L. Smith (S							Route Number, (ithsburg			
Baltimore, I	Pages 1 and ent of Heelt nt: If Item 2' ry or other		20a. Method of Disposition 1 1 1 1 1 2 1 2 2	Removal from State	20b. Place of cemeter	Disposition (A y, crematory of ld Ceme	ame of other place) Oc	Da	10,	c. Location	on - City or To	own, State
Balti	permit. Departm Departm Importa eny Inju		21. Signature of Funeral Service Licens	00	MD 1414		and Address	of Facility	005 1 II		5 Bra	gold.M adbury rg.Md.	Ave.
8760, <	Physician and // Medical Examiner tube prize and tube prize tube p	ilcal Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or a)	consequence of	of):	ailu ut-	ue Xadu	ue				Interval Batween Onset and Death Output
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and orge 2 should be detached for use as the burial-transit	Physician/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	l3c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at tir 9☐Unknown	Fetal death	3 □Ectopic 5 □ Other (Date of delive	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying	cause giver	n in Part I.			cco use c		ne cause of death?
Division of Vital Records,	: The law re cete has bee page 2 sho	Completed							-	24a. Was an autopsy performe		prior to con death?	psy findings available mpletion of cause of
₩ 	ician certifi ector	Be	25. Was case referred to medicat examiner?	lospital: _/.					Death ((Check only one)	100000		
on of	ding Physician: h. After this certifica funeral director,	tlon: To	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. T	tpatient 3 () Time of njury M	28c. Injury	4 Nursin		e 5 Resident			y)
Division	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, fa (Specify)				28	Bf. Location (Stre City or Town,	et and Nu State)	ımber or Rura	d Route Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of ea and manner state	xamination and	, death occurre d/or investigation	d at the time on, in my opi	e, date and planting of the contract of the co	ace, an	nd due to the cau d at the time, date	se(s) and and place	manner as si	tated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier Wayeu	gone	4		9c. License		_			ned (Month,	
95	7		30. Named and address of person who co	ompleted cause of dea	th (Item 23a) (Type, Print)	Stre	U- 1-	ters	zerst on	w	MDZ	(740
	Sta Registi	-	31. Date filed (Month, Day, Year)	32 Registrar	s Signature								

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month . 2005 Yeer Sept. 25, Kay Morgan Snyder 8:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7343 Bozman-Neavitt Road Bozman Talbot If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 6, 1947 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 M 2 1 153-40-6662 58 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Talbot Bozman 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7343 Bozman-Neavitt Road 21612 **USA** death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ğ 3 Widowed 4 Divorced White "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Educator Private Education other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ant: If itam 27 Is marked oth jury or other traumatic even James G. Morgan, Jr. Eleanor Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Emig Snyder/Spouse 7343 Bozman-Neavitt Rd., Bozman, MD 21612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. MidShoreCremationCenter 9/26/2005 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mid Shore Cremation Center, P.O. Box 1464,
2272 Hudson Rd., Cambridge, MD 21613 Signature of Funeral Service Licensee Attoried of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Tart1. Enter the disease, or complicationshock, or heart filline. List only one calls Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** 2months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death hed by the all 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificate 2 No 1 Tyes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1☐Yes 2☑No Certification: To Sid completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Director: After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month. Day, Year) 3988 26 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 Pintail Drive, Easton, MD Dr. David H. Smith, 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 2 6 2005

For Amend Items 23842592Mazsane/pepaminessi http://the/nobilesstal Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 21, **Physician** 2005 Year James Daniel Sharp 10:15 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner William Hill Manor Easton Talbot 8. Date of Birth (Month, Day, Year)
Sept. 8, 1919 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12 M 2 F 217-05-5087 86 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho 1 Yes 2 No Directo Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10193 Hiners Lane 21601 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ ¥es 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. If item 27 is marked other than in other traumatic event, The Me Elementary/Secondary (0-12) College (1-4or 5+) Service Manager Propane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) D. Raymond Sharp Laura Wooters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy L. Sharp/Son 34 Algonquin Rd., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny Injury or o 1 Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WoodlawnMemorialPark | 9/27/2005 Easton, Maryland 2) Signature of Fun all rvice Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respondent or heart tailure. List only one cause on each line. Cambridge, MD as cardiac or respiratory arrest, atory arrest, Approximate
with complications and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ICATI APPRO E VINEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the anderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 Yes 2□ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 22 Certification: To 28a. Date of Injury (Month, Day Yea 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Divatural 2 Di Accident 5 Pending 08/03/2005 Unknown 1 Tes 2 No investigation Subject fell Il Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At home 28f. Location (Street and Number or Rural Route Number, within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 | Homicide 10193 Hiners Lane, Easton, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125750 05

Registrar

DHMH 17 Rev 1/2001

State

21601

Robert B. Sanchez, M.D., 508 Idlewild Avenue, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, DSEP) 2 6 20052. Registrar's Signature

				partment of ertificate of				g. No.	33261
cian	Decedent's Name (First, Middle, La		011	*			Date of Death Month	4, Day 2005 Yea	3: 50 A M
dical iner	4a. Facility Name (If not institution, gir	uglas MacAr	cnur Sull	4b. City, Town,	or Location		tober	4c. County of De	
iner	22810 Goddard Court			Leonard				St. Mary'	
1	5. Social Security Number 6.5	Sex 7. Age	(In yrs. last birthda		r If Under		Date of Birth Month, Day,	. 9. B	lirthplace (State or Foreign Country)
	215-38-7425	1⊠M 2□F	64 Yrs.	World's Duys	riours				trict of Columbi
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
to	Maryland St. Mary		Leonardtov	m					1 ☐ Yes 2 ☑ No
Director	10e. Street and Number	5	Econardeov	10f. Zip Code			10	g. Citizen of What	Country?
	22810 Goddard Court,	Apt. # 58		20650			τ	JSA	
Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 No	Specify:	,		Specify: W	hite
	15. Decedent's E	ducation		edent's Usual Occu			1	6b. Kind of Busines	
ple	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	life	re kind of work done . DO NOT use retire	e during mos ed)	st of working			,
Completed	8	Conlege (1 401 01		sekeeper				Hospital	
Be (17. Father's Name (First, Middle, Las	t)			18. Mothe	er's Name (Fir	st, Middle, M	faiden Sumame)	
은	Joseph F. Sullivan	<u> </u>				ian J. Kr			
	19a. Informant's Name/Relationship							City or Town, State	, Zip Code)
	Marie K. Goode-Spence	er / Sister	20b. Place of Dis	1005 Box 56 position (Name of		AE 0959.		Oc. Location - City	or Town, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Contr		i	ematory or other plants		Octobe	er		
ľ	21. Signature of Funeral Service Lice	•		22. Name and Add	ress of Facili			eonardtown,	Maryland
	Touchard Xun	i Hardin	M. M.	lattingley-(Gardiner	r Funeral	Home,	P.A.	
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to	ne death. Do not e	nter the mode of dy	ring, such as	cardiac or res	piratory arre	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition	,		Cancer					Onset and Death
	resulting in death)	Due to (or as a	consequence of):	Jancer					
	Sequentially list conditions,	b							
Jine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usesse of Figure that initiated events	Due to (or as a	consequence of):						
Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
dlcal E		. d							
ledle									
Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		B Ectopic pregnan	cv			23d. Date of c	,
sicla	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐Pregnant at ti		Other (specify)				Month	Day Year
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by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	iven in Part I	l.			to the cause of death? Probably 4 Dunknown
etec									
Completed							24a. Was an autopsy perform	prior t	autopsy findings available o completion of cause of
	05 111-						1 ☐ Yes 2	XNo 1□Y	s 2∑X No
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	t 2 ER/Outpat	20 DOA 0	thor	e of Death (Ch			
-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c, Inj	4 LINU			nce 6 Other (Sp w injury occurred	Decity)
atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injun		ork? ⊒Yes 2□	No			
tifica	3 Suicide 6 Could not determined		y - At home, farm,	street, factory, office	9	28f. I	ocation (Str. City or Town,	eet and Number or	Rural Route Number,
Certification:		Zamanig, Sto.	,			il il	,		
ica	(Check only 2 Medical Exe	thysician: To the best of eminer: On the basis of e	examination and/or	ath occurred at the investigation, in my	time, date an	nd place, and oath occurred at	due to the ca	use(s) and manner te and place, and d	as stated. ue to the cause(s)
Medical	29b. Signature and title of certifier	and manner state	ed.		nse number				``
-	255. Signature and mile of certifier	60-	m					d. Date signed (Mo	
	1000/00	completed source of	ath (Itom 22=) (T	D417	28		00	tober 4,	2005
			aut (Item 23a) (TVD	e, Print)					
	Patrick Cross, M.			eonardtow	m. Ma	rvland	20650		

Registrar

4 2005

			riease	State of Maryland / De				-	
			For State		Certificate of			2005	33263
			Registrar 1. Decedent's Name (First, Middle, Last,		Jeruncate or	Death	2. Date of Death	J. NOF UU	3. Time of Death
	Physici		Betty L.	Thomas			Month	Day Year er 27, 20	
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, o	r Location of Deat		4c. County of Dea	
			Laurel Regional I	Hospital	Laurel			Prince G	eorge's
	Funeral		Social Security Number 6. Security Number	TM 247E	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,)	(ear) 9. Bii	thplace (State or Foreign ountry)
	Director		296-18-4761 Usual Residence of Decedent	83 Yrs	s.		Aug. 27,	1922 Oh	io
Poet	Mo m		10a. State 10b. County	10c. City, Town o	or Location		-		10d. Inside City Limits
Man	Mary led	tor	Maryland Montgome	ry Silver	Spring				1 ☐ Yes 2 👿 No
ď cď	or 28g	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What C	ountry?
booten of the time the ob	The will make the way a state to be all will me way a lat Hygiene Hygiene do ther than "natural", or liems 23a or 28a-f show avent, the Medical Examiner must be notified at		3128 Gracefield R	oad, Apt. 103	20904			USA	
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
9500	JO.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1943-45	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite
3	within 72 nous aries ane. than "natural", or ite ha Medical Examina		15. Decedent's Edu	ication 16a. D	ecedent's Usual Occup	ation	16	6b. Kind of Business	
ָר <u>י</u>	E E	ple	(Specify only highest grad	College (1-4or 5+)	Give kind of work done fe. DO NOT use retired	during most of wor d)	rking		•
7	e filed withing al Hygiene. other than " vent, the Me	Completed	12		ecretary			F.T.C.	
and	d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	
	s should be and Mental Is marked (은	Emmett H. Marsha			Ruth W			
	perimit. Tages 1 and 2 should on Department of Health and Menta Important: If item 27 is marked any injury occither traumatic avonce.		19a. Informant's Name/Relationship (Ty Steven A. Thomas/		Mailing Address <i>(Street</i> D Great Ris				
<u>ရာ</u> ် နိ	Heall tem 2		20a. Method of Disposition	20b. Place of D	isposition (Name of	1		c. Location - City or	
baitimore,			1 Burial 2 Cremation 3 F `4 Donation 5 Other (Specify)	Temoval from State	crematory or other place Memorial Park	peb		ockville,	Maruland
	oortan yortan / inju		21. Signature of Funeral Service Licens		22. Name and Address J.				Haryrand
מ			dames 9	Ocoley	500 Univer	sity BIV	a, W, Sil	ver Sprin	g, MD 20901
			23a. Part1. E Ver the disease, or compl shock, or yeart failure. List only or	ications that caused the death. Do not no cause on each line.	enter the mode of dyin	g, such as cardiad	or respiratory arres	t,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a Myocardial Infa					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
		5	Sequentially list conditions,	b. Coronary Artery Due to (or as a consequence of):					
4	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Junderlying Cause (Disease or injury						
,	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequence of):	:				
- 9	9 % 9	icat		d					
20	deam certificate attending phicated for use as the	Med	IF FEMALE:						
מסא	uttend or us	lan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	the a	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)				
J 3	deta	y Ph	Part II. Other significant conditions con	ntributing to death but not resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	een sign	d by					1 🗆 Yes	2 No 3 P	obably 4 Mnknown
Ü :	9 70	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
Ĭ,	9 - 0	mo					autopsy performs	d? death?	completion of cause of
_	s certificate irector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)	7110	
2	· ·	10	1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 XER/Outpa	atient 3 DOA Oth	er: 4 □ Nursing H	ome 5 🗆 Residenc	ce 6 ☐ Other (Spe	cify)
<u> </u>	5 (g 6	on:	27. Manner of Death 1 Xiatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injur	/ at	28d. Describe how		
ols!	Attending ir death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	30 - Place of laiste. At home form		Yes 2 □No	296 Legation (Ctra	at and Mumber of D	- L Double Museline
- ;	F = E	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, ractory, onice		City or Town,	et and Number or Ri State)	Irai Houte Number,
_ :	e nospital 124 hours af a Funaral D letely filled i		29a. Certifier 1 Cartifying Phy	sician: To the best of my knowledge, d	leath occurred at the tin	ne, date and place	, and due to the cau	se(s) and manner as	stated.
2	n 24 h	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/o and manner stated.	or investigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
1	within 2	Σ	29b. Signature and title of certifier	2107/11	29c. License			. Date signed (Mont	
	14		Just July	M1/40		13375	Se	ptember 2	7, 2005
	,		30. Name and address of person who co Karen Merritt, M.			Silver C-	ring MD	20004	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature		TIVET SD	TING, MD	20904	
	Regist		SEP 2 9 200	05 / suc 15 /	pouls				

				Please I	ype or Print in E							
			1 _ For		State of Marylan				Mental Hy	giene		5 22261
			Registrar			Cer	tificate of l	Death		Reg. No.		- 00.07
	Physicia /Medic		1. Decedent's Name (F	Tirst, Middle, Last) 4 B.	Thompso	N			2. Date of De Month Septem	/ Day	200	3. Time of Death 2:36 A-M
	Examin	er	4a. Facility Name (If no			_	4b. City, Town, or	. [[1		County of De	
W. E.S.	Funeral	1	5. Social Security Num	ber 6. Sex		-	If Under 1 Year	Height If Under 24 Hrs			ince	G-corges inthplace (State or Foreign
	Director		-	993 1	M 200 F	73 Yrs.	Months Days	Hours Min.	JUNE &	O, K	112 1	MARYLAND
Maryland	thow		10a. State	ob. County	10c. Cit	y, Town or Loc	cation	1				10d. Inside City Limits
he Ma	or items 23a or 28e-1 show odner must be notified at	Funeral Director		Rince (reorges CA	pital	Heigh	175				1 MYes 2 □ No
with t	I ben	10	10e. Street and Number 5310 C	"un bac	las Stope	+	10f. Zip Code	743		10g. Citi	zen of What (
death	ms 2	nera	11. Marital Status	MINDEL	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No	0-	14. Race - An	nerican Indian,
after	or Items		1 Never Married	2 Marned	Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give		Yes, specify Cuba	in, Mexican, Puer Specify:	to Rican, etc.)		Black, Wh	
Pours Pours	"natural", adical Era	d by	3 Widowed 4		Year or Dates:					1		erican Indian
137 o	"nat edics	ompleted	(Specify	only highest grade	e completed)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wo	rking	l _	nd of Busines	
Z with	r than	ошь	Elementary/Seconda	ıry (0-12)	College (1-4or 5+)		nema	Ker		10	ome	stic
	othe vent,	Bec	17. Father's Name (Fin	st, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden	Sumame)	,
Vala	Menta arked atic e	To	JAM	ES D	NANN	-		M	Ammi	el	RUCH	OR
Jar 2 sho	ls m		19a. Informant's Name	/Relationship (Ty)	rpe, Print)	19b. Mailin	g Address (Street	and Number R	ural Route Numb	er City o	r Town, State	Zip Cod. 20743
e, l	Health em 27 ther t		20a. Method of Dispos	Inomps	30N/50/V	70 10 Place of Dispos	sition (Name of	u rae	Date	200 10	cation - City of	r wn. State
	nent of int: If It iry or o			Cremation 3 R	Removal from State	emetery, crem	natory or other plac	9/	29/05	01	= Nto	Manuland
	투명로		21. Signature of Funey			Surrecti 22.	ON CEME. Name and Address	ss of stility	~//02	U	114 (8/0	IVIMILY IM O
	Departiment any in		1	1/5	4	19/ A	Jams Fu	ineral H	ome Ac	ill As	co. N	lary land
P*) /			23a. Part1. Enter the shock, or heart fa	sease, or ampli	ications that caused the deat	h. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory	rrest,		Approximate Interval Between
P	ysician		Immediate Cause (Fin disease or condition		Soft tis		Sarcon	/	rearn			Onset and Death
	Medical xaminer		resulting in death)	(Due to for as a conseq	uence of):	6	1		•		= 41-
	Karimiei	e.	Sequentially list condit	tions,	Due to (or as a conseq		tases					Smonths
ted	nsit	xamine	Sequentially list condit if any, leading to imme cause. Enter Underlyii Cause (Disease or inju-	ng diate	200 (0 (0) a 3 CO (1360)	derice or).						
6U, be execu	sicien and burial-transit	Еха	that initiated events resulting in death) Las		Due to (or as a conseq	uence of):						
	ysicien ne buria	ca			d							
Goath certificate	attending physi	Medi	IF FEMALE:									
BOX	ttendi or use	lan/I	23b. Was decedent pr	egnant	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta	Ideath 3 🗌	Ectopic pregnancy				23d. Date of d Month	elivery Day Year
	0 2	Physician/M	1 ☐ Yes 25 N 9 ☐ Unknown		4□Pregnant at time of d 9□ Unknown	ieath 5□	Other (specify)					Suy . ou
J. jā	signed by the a be detached f	/ Ph	Part II. Other significa	nt conditions cor	ntributing to death but not res	ulting in the un	nderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
rds	n sign	d by							10	Yes 2	ZNo 3□1	Probably 4 Unknown
S M	s been si	plete							24a. Was		24b. Were	autopsy findings available
VITAL RECORDS, sician: The law requires t	certificate has t	Completed							auto perfe 1 ☐ Yes	psy ormed? No	death?	o completion of cause of
	ctor.	Be C	25. Was case referred examiner?	to medical				26. Place of De	ath (Check only	_		
	this cert	은	1 ☐ Yes 2 No		lospital:			4 Linuising i	lome Ses			pecify)
on C	death. tor: After the funera	lon		5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	∤at k? Yes 2 ∐ No	28d. Describe	how injur	y occurred	
DIVISION Of VITA	death. ctor: A y the fu	Certification:		investigation 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre		192 5 140	28f. Location	Street an	d Number or i	Rural Route Number,
	l Dire	erti	4 Homicide	determined	building, etc. (Specif		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To			,
To the Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1	Sertifying Phys	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s)	and manner	as stated.
the t	the F	Medi	one) 29b. Signature and title	o of contition	and manner stated.		200 Linner	o sumbos		20d Day	prace, and di	
2	₩ ₩ 00		Lob. digitatore and title	1000000	to VILL.	Mi	DC	-1856	/	Jan. Dal	126/-	nth, Day, Year)
0			30. Name and address	of person who co	projeted cause of death (Iter	n 23a) (Type I	Print)		1		-//	
T	32		David J	T Perry	ner: On the basis of examina and manner stated. Impleted cause of death (Item 2005) 32. Figistrar's Signal (1005)	-ruzas	St NU	! Was	4. DC	200	10	
*	Sta		31. Date filed (Month,	Day, Year)	32. Figistrar's Signa	aturg 1	berte					
-37	Regist	rar	5	LL W I TI	100	- 7	22					

icia	an	Decedent's Name (First, Middle, La	,		ertificate of De		2. Date of De Month	ath Day	005 Year	3 3 2 6 5 3. Time of Death
dic		Patricia Louise					Septemb	1		12:40 A ^M
nin	er	4a. Fecility Name (If not institution, gir			4b. City, Town, or Lo				ounty of Deeth	
		10199 Campus Way 5. Social Security Number 6.		a (In yrs. last birthda	Upper Man	f Under 24 Hrs.	MD 8. Date of Bir		nce Ge	
al or			1□ M 2(X F	57 Yrs.		Hours Min.	Oct 6,	y, Year)		place (State or Foreign Intry) tsburgh, PA
Office and	tor	10a. State 10b. County Maryland Prince	Georges	10c. City, Town or Upper Ma						10d. Inside City Limits 1X Yes 2 □ No
	ai Director	10e. Street and Number 10199 Campus Way	South		10f. Zip Code 20774			10g. Citize Unite	n of What Cou	untry? es
	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		I. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		. Race - Amer Black, White pecify: B1	, etc.
	Completed	15. Decedent's E (Specify only highest gr	rade completed)	(Giv	edent's Usual Occupation we kind of work done during DO NOT use retired)	on ing most of work	king	16b. Kind	of Business/l	ndustry
	mo	Elementary/Secondary (0-12) 12 yrs	College (1-4or 5	+)	ountant			Pri	vate	
	To Be C	17. Father's Name (First, Middle, Las Ernest Evans Mor	ot)		18	B. Mother's Nam	ne (First, Middle, Osborne			
The second second		19a. Informant's Name/Relationship William Turner /			iling Address (Street and 99 Campus Wa					
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		20b. Place of Discemetery, co	position (Name of ematory or other place) ction Cemete	ery 9/2	Date 26/2005		tion - City or T	
- BAIIN		21. Signature of Fune at Service Lice			² Роре «Рипета	a EacHomes	s. P.A	5538	Mar1b	oro Pike.
		Lamed.	Demm							,
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	-	the death. Do not e	Forestville	such as cardiac	20747 or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused y one cause on each lin a. Due to (or as a b. Due to (or as a c.	the death. Do not e		such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1ten 16a per fh 9848 10-13-05 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29, Clinton Sept. 0. Turner 2005 06:09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda
If Under 1 Year | If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5, 1938 **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 225-44-2856 Yrs. Director 67 May VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other then "naturel", or itsms 23e or 28e-f showers the Medical Examiner must be notified at Director 1X Yes 2 □ No Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 811 Booker Drive 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2 □ No If Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: Black þ 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Year or Dales: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Procurement Specialist 12 permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If Item 27 is marked other tt any Injury or other traumatic avant, III once. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Turner Annie Mae Leech 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er 1114 21st St. NE #105
Washington, DC 19a. Informant's Name/Relationship (Type, Print) Floria Turner-Glover/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crem. 10/5/05 Riverdale, MD. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sign no e of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Pmd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Gastrointestinal Hemorrhage 3 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year signed by the at d be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No : After this certifica e funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpalient 2 TER/OulpatienI 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 XYes 2 □ No 28a. Dafe of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ro the Hospital 1 X Cartifying Physician: To lihe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier / 29c. License number 29d. Date signed (Month, Day, Year) D37891 September 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Arajvanshi, MD, 121 Congressional Lane, #409, Rockville, Md. 20852 31. Date filed (Month, Day, Year) State OCT 1 3 Registrar

nysician	Registrar		Cei	rtificate of l	Death		Reg. No.	0 0	3326
o energial i	1. Decedent's Name (First, Middle, L Robert Van Gil					2. Date of De	ath 24	2005	3. Time of Deat
Medical xaminer				4h City Town or	Location of Death	<u> </u>		V of Death	0605
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neral	Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Fore
ector	508-24-8340	1₩ 2□F	78 Yrs.	Months Days	110013	Oct. 2		Iow	
13	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					0d. Inside City Lir
tor to	Maryland Anne A	rundel	Annapoli	\$					1 XX Yes 2□
te notifica Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
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directional Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No Rican, etc.)		ce - Americ	
event. Its Medical Eracities must be notified at Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ITTES, GIVE	° 1950–1952	1 ☐ Yes 2 No	Specify:		Speci	fy:	
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treu	Margaret Van Gil			Boucher A					C008)
any injury or other treumatic once.	20a. Method of Disposition		20b. Place of Dispo	ALCOHOL TO THE PARTY OF THE PAR		Date	20c. Location		wn, State
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	Physici		Decedent's Name (First, Middle, Las JEANNE		LENTIN	ı Er			2. Date of Dea Month Sept	Day	Year 005	3. Time of De 3:29F	
13	/Medic Examir		4a. Facility Name (If not institution, give		TENTT	i E	4b. City, Town, or	Location of D		4c. County	of Death	1	
		4	Shady Grove Ac		Hospi		Rock	ville	Hrs. 8. Date of Birt			mery	
	Funeral Director				78	Yrs.	Months Days		Min. Oct. 1	, 1926	9. Birthp Cour Was	lace (State or F (ry) h, DC	oreign
	ehow	ř	10a. State 10b. County MD Montgo	meru	10c. City, To		cation aytonsv	ille			1	0d. Inside City I	
	the M	recto	10e. Street and Number	Titely]		10f. Zip Code			1 ŽYes 2 10g. Citizen of What Country?			
	23a of	al Di	20320 Rose The	orn Ave				0882		U.S.A.			
036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show many nury or other treumatic event, the Madical Examinar must be nutified at another.	by Funeral Director	11. Marital Status **Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1/2 If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cubar I □ Yes 2X No	spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Raci Blac Specify	e - Americ k, White,		
21215-0036	within 72 ho iene. 'than "natu iha Madical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	cation fe completed) College (1-4or !		(Give lite. l	lent's Usual Occupa kind of work done d DO NOT use retired, NESTIC	furing most of	working	16b. Kind of Bu		lustry	
and	ntal Hyg ed other: event,	Be	17. Father's Name (First, Middle, Last)	ing Cr		Don			Name (First, Middle, neva Ken	Maiden Surnam			
37	should nd Mer nark	٦°	Hugh Valent: 19a. Informant's Name/Relationship (7		19	b. Mailin	g Address (Street a		r Rural Route Numbe		State. Zio	Code)	_
Baltimore, Maryland	and 2 ealth a m 27 is		Hugh Valentine	Jr-Brot	her 2	2032	0 Rose	Thorn	Ave Lay	tonsvi	lle,	MD2088	32
nore	nt of H		20a. Method of Disposition 1 XBurial 2 Cremation 3		cemet	ery, cren	sition (Name of natory or other place		Date	20c. Location -		wn, State	MID.
altin	ortme ortme		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licent		Gate		Heaven Name and Addres		.1.2005 Snowden				
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	Physician /Medical		23a Part1. Enter the discase, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. A CUL	e mo	Coc	-dian ir	-fare-	101		1	Approximate Interval Between Onset and Dea	en ath
8760,	Examine be executed physicien and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence a consequence		1 laren	w. 2.3	er leas	VIS BASE		1000	
O. Box 6	The law requires that the death certitics ate has been signed by the attending ploage 2 should be deteched for use as it.	by Physician/Med	IFFEMALE: 23b. Was decedent prøgnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			23d. Date Mor	of delive	ry Day Yea	ır
rds, P.	w requires that been signed b should be dete		Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause give	n in Part I.		bacco use contr	bute to th		
Division of Vital Records,	: The law requ cate has been , page 2 shoult	Completed							24a. Was autop perior 1 □ Yes	sy p med? d	rior to con eath?	sy findings ava appletion of caus	ulable se of
<u> </u>	Physician: r this certifica ral director, p	Be .	25. Was case referred to medical examiner?	Hospital:			Othe		Death Check only o				
ion of	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funerel Director: After this certilicate has completely filled in by the funeral director, page 2	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Injury Work	4 🗀 Nursin	g Home 5 ☐ Resid 28d. Describe h	ence 6 □Othe ow injury occurre)	-
DIVIS	ital or Atti rs etter de rel Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, f c. <i>(Specify)</i>	arm, str	eet, factory, office		28I. Location (S City or Tow	treet and Numbern, State)	or Rurai	Route Number	:
	To the Hospital within 24 hours et o the Funeral I completely filled	29a. Certifier (Check only one) 29a. Certifier (Check only one) 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of								ause(s) and mar late and place, a	ner as stand	ated. the cause(s)	
	To the Within 2 To the complet	M	29b. Signature and title of certifier	O \	1	w	29c. License	number		29d. Date signed	(Month, L	Day, Year)	
	4		30. Name and address of person who c	moleted assured	leath (trong on	2 -	D004	580)	5 5	septem!	ser.	24 20	05
			Jonathan Wenk					Rockv	ille. MD	20850			
1	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 200	32 Registr		600							

			1 - For State Registrar	State of Maryla		nent of Health and cate of Death		2005	33269
	Physic /Medi		1. Decedent's Name (First, Middle, La LKVcy Lh	it Jr.	-		2. Date of Death Month	Day Year 6 2005	3. Time of Death 2
	Examir		4a. facility Name (If not institution, given the facility Name (If not institution, given facility Number) 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 16. Social Security Number	u medicas Cer	Her	City, Town, or Location of Dea Sallsburg Inder 1 Year If Under 24 Hr.		4c. County of Death	ico
	Funeral Director			F 7. Age (In yrs		iths Days Hours Min		ear) 9. Birth	nplace (State or Foreign untry) U. S.A.
	the Marylan 28a-f show notified at	ctor		10c. C	ty, Town or Location	land			10d. Inside City Limits 1 XYes 2 No
	ath with the 23a or 2	Funeral Director	301 Dular	ey Ave		1. Zip Code 2 1824		Citizen of What Con	untry? 1.
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at	b	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 D Mo If Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puel	Specify Yes or No- no Rican, etc.)	14. Race - Amer Black, White	
21215-0	filed within 72 h Hygiene. ther than "netu ont, ire Medical	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give kind of life. DO NO	Usual Occupation of work done during most of wo T use retired) to crev	orking 16	b. Kind of Business/I	1.1
Maryland 2	should be filed ind Mental Hygi marked other umatic event.	To Be C	17. Father's Name (Hrst, Middle, Last Levoy Wl	lite Sp.		18. Mother's Na		wsend	
e, Mar	1 and 2 sho Health and Iem 27 is m		Barbara U	Thite Daught	e 101		se Sal	isbury,	md, 21801
Baltimore	t. Page rtment o rtant: if		20a. Method of Disposition 1 Surial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State Sq	Place of Disposition cometery, crematory	or other place) ys Cem. 9.	Date 200	Princes	1
Ba	Depermine Composition of the Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		21. Signature Funeral Service Lice	E. Walf	30	e and Address of Facility (den Hue	Dence	ST Anne MY
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.		mode of dying, such as cardial		,	Approximate Interval Between Onset and Death
8760,	executed make by sician and purial-transit he burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of): very high (quence of):	Cardlo Vascu	0.00		
.O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	Il death 3 □Ectop	ic pregnancy r (specify)		23d. Date of deliv	rery Day Year
<u>α</u>	quires that t in signed by uld be deta	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyi	ng cause given in Part I.		co use contribute to t	the cause of death?
of Vital Records,		Completed					24a. Was an autopsy performed 1 Yes 2 22	prior to co death?	opsy findings available impletion of cause of
f Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Tyes 2 Tylo	Hospital: 1 Inpatient 2	ER/Outpatient 3	Oth	ath (Check only one)	e 6 ☐Other (Speci	fv)
	ing After une	ertification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Division	Hospitel or Attend 44 hours after death Funerel Director; / 1ely filled in by the f	O	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specif	y) 		28f. Location (Street City or Town, St	fate)	
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exer	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	red at the time, date and place tion, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	to Ald		29c. License number	1	Date signed (Month,	Day, Year)
				completed cause of death (Item	n 23a) (Type, Print)	D 32014	9	17/15	
			MAJESIJ MIO) 31. Date filed (Month, Day, Year)	completed cause of death (Item 32. Registra's Signa 9 2005	106 Mil	150 vd 51. 50	4B 5411	sbyry n	1721804
	Sta Registr		SEP -	9 2005	. K	andi)			

Baltimore, Maryland 21215-0036

-transit and physicien at s the burial-t P.O. Box 68760. 2 should be deteched for use as Division of Vital Records, page the funeral director,

1 - For State Registra Certificate of Death Reg. No 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OG **Physician** 10,49 am May Wherley 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rose da le If Under 1 Year If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) Franklin Square
5. Social Security Number 6 11 more 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF 86 Months 212-03-0520 Director Oct. 23, laney town, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23s or 28s-1 show with Injury or other traumatic event, Item Aulical Examination and once. Baltimose Kingsville, MD 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA. Road 12120 Glenbaue 21087 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) ome Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1aude E mer Krise 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road, Kingsville, MD 21087 12120 Glenbauer Donia Oaster Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 Removal from State Sept. 28,2005 Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hanou 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stephen K. Miller Wetzel Funeral Howl, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heuteinterior /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to animounate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 menths? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hnemia 4 Donknown 1 Yes 2 No 3 Probably Be Completed History of CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 No 1 ☐ Y*e*s 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 □Yes 2 □ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier one) ţ, 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a 2. Print Print) 9 in you That M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylar	nd / Depa	artment of F rtificate of	lealth and Death	Mental Hygi	en 2 0 0 5	33271
	Physici	an	Decedent's Name (First, Middle, Last	7	Wall	4		2. Date of Death Month	Day Yea	
	/Medic		4a. Facility Name (If not institution, give	street and number)	Wall		or Location of Dea		4c. County of De	- 1.0
			Coastal Hospice a			Salisbu			Wicomi	
	Funeral Director		5. Social Security Number 6. Se 266-54-5122 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		rear)	Sinthplace (State or Foreign Country) S.C.
	yland Jow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Be-1 s	Director	Maryland Wicomico	sal:	isbury					¥⊠Yes 2 □ No
	within 72 hours after death with the Maryland ene. than "natural", or itame 23a or 28e-f show its Maylical Exercites the nutiliar at		10e. Street and Number		,	10f. Zip Code		10	g. Citizen of What (Country?
	death	nera	Winder Street 11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)		nerican Indian,
36	or its	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		ir Yes, specify Cub 1 ☐ Yes 2 ② No		nto mican, etc.)	Black, Wh	nite, etc.
Ö	2 hour	ed b	3 ☐ Widowed 4 💆 Divorced 15. Decedent's Edi	Year or Dates:	16a. Dece	dent's Usual Occur	pation	1		ack
212	thin 72 e. en "na	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of we	orking	MovingCom	,
27	filed wi Hygien other th		11th 17. Father's Name (First, Middle, Last)		Truck	Driver	10 Markada Na	(First Middle Ad	tilde of the same	
Maryland 21215-0036	id be f ental F ked of ic ever	To Be	Seymour	Wallace			Mary	ame (First, Middle, M Viola		ison
ary	2 should and Men is marke	-	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street		Rural Route Number,		
	D = ► ≥		Henry Wallace/son		4510	Lord's L	ndg RD,			20772 arlboro, MD
altimore,	permit. Pages 1 an Department of Heel Important: if Item 2 any njury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Tomovar nom Otato		sition (Name of matory or other pla			0c. Location - City of	
틡	permit. Pag Department Important: i any injury o	1	4 □ Donation 5 □ Other (Specify, 21. Signature → Funeral Service Licer)		ght's	Fam. Ceme 2. Name and Addre		0/2005 Ed		
Ö	Departition Depart		Soretta D	Allow		OLLEY MEN	1.4		Road - S	Salis., MD 21801
31			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused he dea ne cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory arres	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MRTASTA	Tic C	ARCINU	MA O	F PROS	TATE	Onset and Death 2 Y /2 5
3	Examiner			CCLON	quence of):	RCING				7000
	P =	ner	if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec						1/2
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					
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9	rtificate ng physi as the t	Medic	IF FEMALE:							
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Fet	al death 3	Ectopic pregnanc	у		23d. Date of d	elivery Day Year
o.	that the de led by the a detached f	Physician/Me	1 Yes 2 No	4□Pregnant at time of a 9□ Unknown	death 5	Other (specify) _			World	Day real
a, G	res that igned b be deta	by Pt	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	icco use contribute	to the cause of death?
Division of Vital Records,	w require been sig should b							1 🗆 Yes	2 2 1 1 1 1 1 1 1 1 1 1	Probably 4 Unknown
Rec	The law ele has b page 2 sl	Completed						24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
ta 		a)	25. Was case referred to medical				OS Plane of De	1 Yes 2	X No 1 Ye	es 2100
<u>=</u>	S D	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott		eath <i>(Check only one)</i> Home 5 🗆 Residen		ecity) HCSPICA
o uc	ling P		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ry at rk?	28d. Describe how		1103.
/isic	Attendii death. ctor: A	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, str		Yes 2 □No	28f. Location (Stre	eet and Number or I	Rural Route Number,
á	tei or A s efter al Dire ed in by	Certification:	4 Homicide	building, etc. (Speci	ify)			City or Town,	State)	in a rodio varioo,
	To the Hospitel or Attending Ph within 24 hours elfer death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	vsician: To the best of my known iner: On the basis of examination and manner stated.						
	To the within To the comple	Med	29b. Signature and title of certifier	and maillier stated.		29c. Licens	se number	290	d. Date signed (Mor	nth, Day, Year)
	(0)) Ste	~ /	Za	De	0584	10	9/25	105
	2		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)		1-		y icu). 2/80/
150	Sta	te	31. Date filed (Month, Day, Year)	32. Resistrar's Sign	ature	1-1-Chil	W (CU 1)	(1.)2	- L1515012	y ha). 21201
1	Registr		SEP 2 8 2	005 Kaling	H. 1	Cars 1				

State of Maryland / Department of Health and Mental Hygiene-For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year lliams Charles 7:00a september 23,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Clinton Clinton Nursing Home | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept. 2, 5. Social Security Number 7. Age (In yrs. last birthday)
73 Yrs. 9. Birthplace (State or Foreign Country)
Bowie, Md. **Funeral** Months 1 3M 2 F 217-34-0925 1932 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at ¥ Yes 2 No Prince Georges Forestville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2737 Lorring Dr. 20747 United States or Itama 23a Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after inent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ital Black, White, etc. 1√ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic avant, the Mudicul 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Edward William Rosetta Henson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Medley / Niece 5568 Livingston Terrace Oxon Hill, Md. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Humportant: if Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Resurrection Sept.30,2005 Clinton, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see Alexander S. Pope Funeral Homes, P.A. 5538 Mariboro Pike/Forestville, Md. 01005 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Theroscleration **Physician** Landis Vancilar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE 9SU 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 0 detached the 9 Unknown 9 Unknown þ Division of Vital Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2€ No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 TYes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funerel Direct filled in by 4 🗌 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 100 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 045365 30. Name and address, pf person who completed cause of death (Item 23a) (Type, Print) lingsta Nd Holftwashigta 10 20745 michael Sida 31. Date filed (Month, Day, Year) State Registrar SEP 2 9 2005

			For State Registrar	State o	f Marylan		artment of H		d Mental H	ygiene	0.0.	n II
	Physic		Decedent's Name (First, Middle	orothy Mc	Connell	Walle	r		2. Date of D Month Octobe	eath Day	005 Year 2005	3 т _т 2 годиЗ
	/Medi Examir		4a. Facility Name (If not institution 8 Park Lane			Walle	4b. City, Town, or Elktor			4c. 0	County of Death Cecil	1023 11
	Funeral Director		5. Social Security Number 180–12–6670	6. Sex 1 ☐ M 2 📉 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours I	Min. 8. Date of B	irth Day, Year) , 192	9. Birthp Count Del:	lace (State or Foreign aware
	Aaryland f ehow ed al	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Ceci	_		, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23e or 28a-f show or other treumstic event, the Wedfeal Exament nust be notified at	by Funeral Director	10e. Street and Number 8 Park Lane				10f. Zip Code 21921			Un	en of What Coun	ates
980	ours after de ral', or Item Exeminario	by Fune	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	ried 1 ☐ Yes	2 🕅 No /e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🏋 No	ispanic Origin in, Mexican, P Specify:	? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
21215-0036	within 72 he ene. then *natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired ministrat	during most of ()			d of Business/Ind	•
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-	ss 1 and 2 sho of Health and N item 27 is ma		19a. Informant's Name/Relations Phy11is Crabt			32	Cami Way,	E1kto	or Rural Route Num. on, Maryla	and 21	921	
Baltimore	Pa ent ury		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	Specify)	State Hea	for chi sbyteri	esition (Name of matory or other place ristiana an Cemetery 2 Name and Addres	† :	tobër 7, 2005	Newa	ation - City or To	
Ba	Permit Depart Import Import Permit Properties Permit Permi		23a. Part1. Enter the disease, o shock, or heart faiture. List Immediate Cause (Finat disease or condition	8. H	aused the death	. Do not en	3 W. Sto	g, such as car	inerals, l Street, E. rdiac or respiratory	lkton,	, Maryla	nd 21921 Approximate Interval Between Onset and Death
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Vital	N S	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hoepital	Inpatient 2	ER/Outpatier	nt 3 DOA Oth		Death (Check only		Other /Specify	*)
Division of	fter fter	Certification; T	27. Manne of Death 1 Natural 5 Pendii 2 Accident invest 3 Suicide 6 Could	gation	of Injury th, Day Year)	28b. Time o Injury	M 1 🗆		28d. Describe			,
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	n 24 hc	Medical	(Check only 2 Medical one)	ng Physician: To the Examiner: On the b and man	asis of examinat er stated.	ion and/or in	vestigation, in my o	ne, date and p pinion, death o	pace, and due to the poccurred at the time	date and p	ind manner as st place, and due to	ated. the cause(s)
	To the vithin comp	M	29b. Signature and title of Sertific	Hospi			29c. Licenso	number 5653	3	29d. Date	signed (Month, I	Day, Year)
	4	ate	30. Name and address of Gerson Martha Hosford 31. Date filed (Month, Day, Year	, M.D., 11	,	High S	,	iite 10	4, Elktor	ı, Mar	yland 2	1921
DH	Regist	rar	OCT 1		du l	× A	and i					. •
						ORIGINA	AL					

/Medio		Decedent's Name (First, Middle Xian Jan Zheng Aa. Facility Name (If not institution,			4h City Town		2. Date of Death Month September	Day Year	
Examir	er	Sidewalk, 5607							
uneral				rs. last birthday)	If Under 1 Year	illum If Under 24 Hrs.	8. Date of Birth	Prince (eorge's
rector		none	¹□M 2ĀF 18	Yrs.	Months Days	Hours Min.	11-9-198	36 Chi	thplace (State or Fore ountry) .na
		Usuel Residence of Decedent							
ehow Mark	_	10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Lin
or 28a-f ehov be notified at	Director	MD P.G.	Ch	illum	T				1 ★ Yes 2 □
10 2	ä	10e. Street and Number			10f. Zip Code			g. Citizen of What C	ountry?
те 23e	erai	3300 Chauncey I	12. Was Decedent Ever in	1115 13	Was Decedent of H			China 14. Race - Am	orioon Indian
or to	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	10.0.	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	lican, etc.)	Black, Whi	te, etc.
n natural', Medical Ex	Completed	15. Decedent (Specify only highes	s Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	g 1	6b. Kind of Business	/Industry
른류	E	Elementary/Secondary (0-12)	College (1-401 5+)	Stud	ent			School	
vent, the	Bec	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
arked atic e	P P	Xin Bin Zheng				Rui Zheng	Zhang		
- E		19a. Informant's Name/Relationsh				and Number or Rural			
m 27 her tr		Xin Yun Zheng			V-	Pl. Apt.			
Important: if item 27 is marked other eny injury or other traumatic event, once.		20a. Method of Disposition 1 Burial 2 □ Cremation		cemetery, cre	osition (Name of matory or other place	De De	ate 2	0c. Location - City or	Town, State
tant:		4 □ Donation 5 □ Other (Sp			oln Cem.		-2005 Br	entwood,	MD
eny in		21. Signature of Funeral Service L	icensee // //		2. Name and Addre	rt.	Lincoln		
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MARYAM ALBERTINI	остовек 11, 2005 1:00 р.ш.
Division of Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
al or Attending Physician: The law requires that the death certificate be executed in Signal State that the death.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Ma Department of Health and Menial hygiene. Important: If Itam 27 Ia marked other than "natural", or Itema 23a or 28a-f
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	_1	For State Registrar	State of Maryland	/ Depa	irtment of Heal tificate of Dea	th and M ath		gierne Reg. No.	005	33275
Physicia: /Medica	n al	1. Decedent's Name <i>(First, Middle, La</i> Maryaın Kadjar A	lbertini				2. Date of De Month Octobe		1,200°	3. Time of Death 1:00 P.M
Examine Funeral		4a. Facility Name (If not institution, giv Stella Maris Hosp 5. Social Security Number 216-46-3934	pice	it birthday) Yrs.			8. Date of Birn (Month, Da May 22	Ba		th Ce County thiplace (State or Foreign bunty) an, Iran
Director 288-f ahow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo			May 22		en of What Co	10d. Inside City Limits 1 □Yes 2 No
urs after death with al', or itema 23s or	by Fur	2300 Dulaney Vall 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	ey Road Apt.M2 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 № No If Yes, Give Year or Dates:	13.	210 Was Decedent of Hispani f Yes, specify Cuban, Me		ecify Yes or No Rican, etc.)	Uni	ited St 4. Race - Ame Black, White Specify:	cates
ed within 72 hou ygiene. ier than "natura t, me weden E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) n/a	(Give life. l	lent's Usual Occupation kind of work done during DO NOT use retired) Home Maker					/Industry Home
nould be fill I Mental H narked oth natic aven	To Be	17. Father's Name (First, Middle, Last, Ahrnad Kadjar			Ma	ry Kad				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "natural; or Items 23s or 28s-f show any injury or other traumatic avent, the Modified Examiner must be multiled at once.		19a. Informant's Name/Relationship (Mr. Guy M. Albert 20a. Method of Disposition 1 □ Burial 2 t Cremation 3 □ 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice)	cini (son) Premoval from State (by)	1160 se of Disponetery, cren s Fun	g Address (Street and N 7 Jenifer R sition (Name of natory or other place) eral Chapel . Name,and,Address of 8	oad T	imonium 2,2005	, Man 20c. Loo Fore	ryland cation - City or est Hil	21093 Town, State .1, Maryland
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a. UTERINE CANO Due to (or as a consequence)	Do not ent	aceful Alte 25 York Roa er the mode of dying, suc	rnativ d Tii	es Fune Monium, or respiratory a	ral&(Mary	yland	on Ctr.,P.A, 21093 Approximate Interval Between Onset and Death
ficate be physicie s the bur	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence) d.							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use es	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3[Ectopic pregnancy Other (specify)			2	3d. Date of de Month	livery Day Year
w requires that been signed t should be det	leted by Pi	Part II. Other significant conditions	contributing to death but not resulti	ing in the u	nderlying cause given in I	Part I.		obacco us		o the cause of death?
	e Comp	25. Was case referred to medical			26.	Place of Deatl	24a. Was autor performed 1 Yes	osy rmed? 2 X No	prior to death?	utopsy findings available completion of cause of
ng Phys	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined.	28a. Date of Injury (Month, Day Year)	NOutpatier 8b. Time of Injury e, farm, str	t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes	□ Nursing Ho	me 5 🗆 Resi 28d. Describe	dence 6 how injury	occurred Number or R	ocity) HOSPICE
	Medicai Cer	29a. Certifier (Check only one) 1X Certifying Pl	hysician: To the best of my knowle miner: On the basis of examinatio and manner stated.	edge, deatl	n occurred at the time, da	ate and place,	and due to the	Cause(s):	and manner a	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier 30. Name and address of person who		(3a) (Tupo		372s		29d. Date	signed (Moni	th, Day, Year)
Stat		DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)		VALI	EY RD. TIM	ONIUM,	MD 210	93		

			1 - For State Registrar	State of N	Maryland / D		tment of H ficate of L			fental Hy	gien	GUUS	33276
	68		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month			3. Time of Death
*	Physici /Medic		Eevald Aarma,DVM							Octobe:	r 13	3, 2005	10:40 A.M
*	Examin		4a. Facility Neme (If not institution, giv	e street and number	er)	4	b. City, Town, or					c. County of Dea	
12		A.	Gilchrist Center					Towso		,		Baltimor	e, Maryland
	Funeral		5. Social Security Number 6. \$ 501-38-0770	Sex 7 F⊡M 2□F	Age (In yrs. last birth 93 Y		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	av Year	1 (rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent							Decembe	er Z	8,1911	Estonia
	/land		10a. State 10b. County		10c. City, Town	or Locat	tion						10d. Inside City Limits
	Mar.	ţċ	Maryland Baltimo	re County	Towson								1 Tyes 2 No
	h the	re	10e. Street and Number				10f. Zip Code				10g. C	itizen of What C	ountry?
	238 C	Funeral Director	508 Goucher Blvd.					21286)		Un	ited St	ates
	r dee	Tue	11. Marital Status	12. Was Decede Armed Force	s?	13. Wa If Y	s Decedent of Hi es, specify Cuba	spanic Ori	igin? (Sp n, Puerto	ecrfy Yes or No Rican, etc.)	D-	14. Race - Am Black, Whi	
36	or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 [If Yes, Give		1 🗆	Yes 2∰No	Specify:				Specify: W.	hite
8	hour	ed b	15. Decedent's E	Year or Date		Deceden	t's Usual Occupa	ation			16b l	Kind of Business	/laduetni
15	n "n	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Give kin	d of work done of NOT use retired,	during mos	t of work	ing		Veterin	,
212	d with	Completed	12	College (1-40	31 3+)	V	eterina:	rian				Medici:	
g	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other then "naturel", or items 23e or 28e-f show event. I'm Madical Exactions must be multired at	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	e (First, Middle	, Maide	n Sumame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene, Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show early injury or other traumatic event, Its Macinal Examination at an angle at an angle.	2	Alexander Aarma							arska			
ā	l 2 sh and r Is m		19a. Informant's Name/Relationship (ng Address (Street and Number or Rui					
	1 and Health Im 27 Ther t		Ms.H.Marie Aarma 20a. Method of Disposition	(Daugnter	20b. Place of 0			lvd.		son,Mar			
ي	ages nt of I		1 Burial 2 Cremation 3		cemetery	cremat	ory or other place	e) ne1	•	2010		ocation - City or	l, Maryland
altimore,	artme ortani injury		4 Donation 5 Other (Special Service Lice)						h.				
B	Depril		21. Signature of Funeral Service Lices	File	min A	Pea	ceful A	ltern	ativ	es Fune	ral	&Cremat:	ion Ctr.,P.A
	8		23a. Party. Enter the disease, or comshock, or heart failure. Last only	plications that caus	sed the death. Do no	t enter t	he mode of dying	g, such as	cardiac	or respiratory a	rrest,	yrand .	Approximate
	Physician		Immediate Cause (Final	one cause on gach	n line.	3	DRE				ory arrest, Approximate Interval Betwoonset and D		
1	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequence of	, ,	2/00						DAYS
1	Examiner		Conventially list and divine	b	,	,.							
25	P #	ner	Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury		es a nonsequence of	Ŋe.							
У	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.									
8760,	icate be executed physician and s the burial-transit	a E		Due to (or	as a consequence of).							
587	ficate phys s the	edicai		_ d.									
Box	nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date of de	livery
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	2 Fetal death at time of death		topic pregnancy ther (specify)					Month	Day Year
0	by th	hys	9 Unknown	9□ Unknowr	1								
	res tha igned be det	by F	Part II. Other significant conditions			the unde	orlying cause give	en in Part I.		23e. Did 1	obacco	use contribute to	o the cause of death?
ord	w requir been si should	ted	COV DITING PATE	my dis	esses	p.e	, Juer	inc		10	Yes 2	No 3□P	robably 4 Unknown
ec	as b	Completed	VASCular di	skase	, hyp	er.	fense	on		24a. Was	osv	prior to	utopsy lindings available completion of cause of
<u> </u>	sician: The law s certificate has t lirector, page 2 s				, ,					1 Yes	rmed? 2 No	death?	2 □ No
\frac{2}{5}	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:			20 DOA Othe	·-		Check only		1404	37
ō	ding Physician: The h. After this certificate hi funeral director, page	To To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpa			28c. Injury	at ⊔ Nu	-	me 5 ☐ Resi 28d. Describe		6 Other (Spe	icity) Hospice
on	th. :: Afte	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, I	Day Year) Inj	ury	Work	:? /es 2 ∐ !			,	,	
Division of Vital Records,	ar degreeto	tifica	3 ☐ Suicide 6 ☐ Could not b	286. Place of	Injury - At home, farn etc. (Specify)	n, street	, lactory, office		T	281. Location (Street a	nd Number or R	ural Route Number,
ā	talorrs afte	Certification:		building,	екс. (эрвспу)					City or To	wii, Stati	θ)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director.	edical	Check only 2 Medical Exam	nysician: To the be	st of my knowledge, s of examination and/	death or	curred at the tim	e, date and	d place,	and due to the	cause(s	s) and manner as	s stated.
	the l	Med	one) 29b. Signature and title of certifier	dge, death occurred at the time, date and place, and due to the cause(s) and and/or investigation, in my opinion, death occurred at the time, date and place									
	T W CO		1 1 1 m	y Hile	ans,		29c. License	20.	-			ober 13,	
	Ì		30. Name and address of person who	completed asset	t death (from 22=) T	une De	7000						
	\wp		A A RELEASE	Completed causers	6701	A/. (harles	St.	6	Balto-	m	1 212	-08
3	Sta	te	31. Date liled (Month, Day, Year)	32. Regi	f death (Item 23a) (T			-	F				
8	Registr	ar	OCT 1 4	2005	que S.	God	sec.						

State of Maryland / Department of Health and Mental Hygiene () 5

Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 09 Day John Shields Aird 2005 09:23p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 108 Delford Rd. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1⊠M 2□F 362-28-5081 85 Director 11-10-1919 Michigan Usual Residence of Decedent filed withIn 72 hours after deeth with the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-1 shov other treumatic event. The Medical Examinar must be nutitied at **Funeral Director** TX Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Delford Rd. 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2∑Married 1 TrYes 2 □ No WWII If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Goverment Demographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Aird (Mary) May Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel Jandy Aird/wife 108 Delford Rd. Silver Spring MD 20904 20b. Place of Disposition (Name of cometer, crematory or other place)
Uniforn Services for the HEalth Sciences 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Depertment (Importent: If any Injury or once. 4℃ Donation 5 ☐ Other (Specify) 10-11-2005 Bethesda MD 21. Signature of Funeral Service Line 22. Name and Address of Facility M0038Z Rapp Funeral & Cremation Service 933 Gist Ave Silver_Spring MD 20910 Stiple & Whamann 23a. Part 1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma 3 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Be Completed 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed? 2**X** No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 TER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 🔀 Natural 5 Pending 1 Yes 2 No death 2 Accident investigation ofter death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tot Bann October 10, 2005 MDO 60335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bannen 9715 Medical Center Dr. #221 Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registra 's Signature 4 2005 OCT Registrar

State of Maryland / Department of Health and Mental Hygieho 0 5For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Leona Marjorie Buck CTOBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALTIMOLE 9000 TOSTITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, MAR 28 Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 X F Months Days Min 265-62-4803 69 Director Canada Usual Residence of Decedent the Maryland 10a, State 10c. City. Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Fuselage Avenue 21220 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "naturat", or Ite any hilury or other traumatic event, the Medical Extrains Black White etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 ρ If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Smith Henry Marjorie Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 Oakland Road, Baltimore, MD Paul Buck - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State Chesapeake Crematory Inc. ' 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2005 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, 8717, Green Pastures Drive; M00986 Towson, MD 21286 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) P.O. | 1 Yes 2 No detached 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 7 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation after death.
I Director: Af 1 TYes 2 TNo within 24 hours after de To the Funeral Directo completely filled in by th 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BAKER, MD TERRANCE 31. Date filed (Month, Day, Year) State

Registrar

4 2005

1

State of Maryland / Department of Health and Mental Hygiene 0 0 5 33279 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OC Lonth 13 Day 200 5 ear William F. Bailey Sr. 7:45am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ivy Hall Nursing Center Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 27 1991 7 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Marynand 1**№**M 2□F 88 213-03-4337 Director Yrs Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar minimal to modified at 10d. Inside City Limits MD Baltimore Director Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 615 Wampler Road 21220 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural" or italy on other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify.White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry College (1-4or 5+) Electrician Elementary/Secondary (0-12) Electric 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry N. Bailey Lillian M. Boston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walter Bailey 613 Wampler Road Baltimore MD 21220 /son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Competent, crematory or other place VA 10/19/05 OwingsMills MD **IX** Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service License 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or comshock, or heart failure. List only o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final andiamyo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by bronic Molimbiha 1 Yes 2 No 3 Probably 4 Tonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? ement a 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: | Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М Diractor: 6 Could not be determined within 24 hours after de To the Funarai Diracto completely filled in by th 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA IN ASBEM. 709. EASTBRN BLVD - M-D - 21221 31. Date filed (Month, Day, Year) OCT 1 4 2005 Glave & Sparke Registrar

			For State Registrar	State of	Marylan	d / Depa	artment e rtificate	of He	ealth a Death	and M	lental Hygi	ene 0	05	33280
	Dhysisi		1. Decedent's Name (First, Middle,	Last)							2. Date of Death Month	Day	Vass	3. Time of Death
√	Physici /Medio		GERALDINE THE	RESA BUCK	LER						OCTOBER	13,	2005	3:30 A M
	Examir		4a. Facility Name (If not institution,				4b. City, To			f Death		4c. Cou	nty of Death	
			OAK CREST VILLA						LLE	2411		BA	ALTIMO	
	Funeral Director		5. Social Security Number 220-62-0978 Usuel Residence of Decedent	5. Sex 1 M 2 XF	7. Age (In yrs. 90	Yrs.	If Under 1 Months [Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 2/7/191	Уөа <i>r)</i> 5	9. Birthp Cour MAR	place (State or Foreign http) YLAND
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mar.	tor	MD BALTI	MORE	7	TOWSON								1 ☐ Yes 2 ☐ No
	th the	irec	10e. Street and Number				10f. Zip C	ode			10	g. Citizen	of What Cour	ntry?
	23a (ai	705 SEABROOK C	OURT			2128	36				US	SA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at Angle.	I by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒Widowed 4 □ Divorced	Armed For	dent Ever in U. ces? 2 ☑No e ites:	'	Was Deceder f Yes, specify 1 ☐ Yes 2 ☐		panic Orio , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify: WH	
5-0	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	tent's Usual C	Occupati	ion vina most	of worki	na 1	6b. Kind of	Business/In	dustry
121	ne. han "	Jdm	Elementary/Secondary (0-12)	College (1-	-4or 5+)		kind of work		n ng moot	01 1101111	9	OT 75.	M HOME	
7	lled v lygie har t		12TH GRADE HOMEMAKER 18. Mother's Name (First, Middle, Last)							de Niess	OWN HOME			
anc	d be f	9 Be	Charles Mill	*				'			i (First, Middie, M H ir sch	alden Sum	iame)	
<u> </u>	Shoul nd Me mark	은	19a. Informant's Name/Relationshi			19b. Mailir	na Address (S	Street an			ITTI SCIT	City or Toy	wn State Zin	Codel
Z	nd 2		Dennis Buckler/	Son			Stever							1045
e,	s 1 a f Hea ltam othe		20a. Method of Disposition			lace of Dispo	sition (Name	of			-		n - City or To	
) E	Page lent o nt: If ry or		1 X Burial 2 ☐ Cremation : 14 ☐ Donation 5 ☐ Other (Spe		state	-	-		1	10/1	5/2005	Parkv	rille.	MD
Baltimore, Maryland	permit. Departm Imports any Inju		21. Signature of Funeral Service L	censee		22	. Name and	Address	of Facility	The		Fune	eral Ho	ome, P.A.
п			23a. Part1. Enter the disease, or of shock, or heart failure. List o	omplications that cannot one cause on ea	used the death	n. Do not ent	er the mode o	of dying,	such as	cardiac o	r respiratory arres	st.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/ = a.	Den	rent	la							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								
	LAGIIIII	<u>.</u>	Sequentially list conditions.	b										
	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequ	uence or):								
	and al-trar	xan	that initiated events resulting in death) Last	c. Due to (c	Due to (or as a consequence of);									
8760,	ate be executed thysician and the burial-transit	alE												
687	ficate physics the	edical		d										
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	Ideath 3□	Ectopic pregi Other (speci						Date of delive	ory Day Year
, P.O.	res that the digned by the be detached		Part II. Other significant condition	s contributing to de	eth but not resu	ulting in the u	nderlying caus	se given	in Part I.		23e. Did toba	.cco use co	ontribute to th	ne cause of death?
Records,	w requires been sign should be	ed by	Viaber	es Me	letu	1					1 ☐ Yes	2 10 No	3 □ Prob	ably 4 Dunknown
၀	aw requisible been 2 should	Completed									24a. Was an	24	b. Were auto	psy findings available
R	The lay	HO									autopsy perform		death?	npletion of cause of 2 No
Vital		BeC	25. Was case referred to medical					- 2	26. Place	ef Death	(Check only one,	No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 NO
Į (nysic alis ce direc	To E	examiner? 1 Yes 2 No	Hospital: 1 🗌 Ir	patient 2	ER/Outpatien	t 3 DOA	Other	. /		ne 5 Residen	сө 6 🗆 С	Other (Specify	()
n of	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date o	f Injury n, Day Year)	28b. Time of Injury	28c.	lnjury a	at	2	28d. Describe how	injury occ	urred	
sio	uttending death. ctor: Aft y the fun	cati	2 Accident investiga	t be			М		9s 2 N					
Division	l or Att after d Direct J in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								l Route Number,			
	pltal ours a aral E													
	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical	one)	caminer: On the ba and mann	sis of examinal	wiedge, death	estigation, in	my opir	nion, deat	d place, a	ed at the time, dat	e and plac	e, and due to	the cause(s)
.6	¥ 3 2 8		29b. Signature and title of definition	MI			D	35	(8	5	6	O (13	3 05	∪ay, 19arj
1)		30 Name and address of person w	no completed seus Per S 329Re 2005	of death (Item	Park	Ville	1/	MD	J	1234			
	Sta Registi	•	31. Date filed (Month, Day, Year) OCT 1 4	2005	yishar s Signa	A April	all .							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day EUNICE BENNETT 1__ /Medical OCTOBER 8:35P 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F 245-30-1495 Yrs Director 82 1922 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits count by notified at Completed by Funeral Director NC 1 X Yes 2 □ No 28a-f Guilford Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a 2426 Merritt Drive Apt. B 27407 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other treumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 □ Divorced Specify: White "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Seamstress Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Edward Simmons Martha Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Rodney Bennett (Son) 821 Laurel Dr., Asheboro, NC 27205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of in Important: If It eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Guilford Mem. Park 10/7/05 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, NC 21. Signature of Funeral Service Lie 22 Name and Address of Facility Hanes Lineberry Funeral Home Mmeur 515 N. Elm St., Greensboro, NC 27401 ennia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** xps15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Examiner Due to (or as a consequence of): anding physician and use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Month Year Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metastatil Lung lancer 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient Certification: To 2 ER/Outpatient this 3 DOA After thi funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 2 Accident investigation 1 Yes 2 No d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Memorial Hospital wresh CHON 31. Date liled Month, Day 4 year 115 32. Registrar's Signature State Registrar

			1 - For State Registrar		of Marylar	nd / Depa	artment of rtificate o	Health f Death	and Mo	ental Hy	ygiene Reg. No	2005	33282
47	Physic	ian	Decedent's Name (First, Midd	le, Last)				-		2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medi		THELMA L. BA							OCT.	10,	2005	5-lop M
	Exami	ner	4a. Facility Name (If not institution				4b. City, Town	, or Location	of Death		4c	. County of Dea	ath
		€. •	PRINCE GEORGE S. Social Security Number	HOSPITAL 6. Sex	CENTER 7. Age (in yrs.		CHEVI If Under 1 Yea		er 24 Hrs.	0.0		INCE GE	
72.5	Funeral Director		578-12-4183	1 ☐ M 2 🙀 F		94 Yrs.	Months Day		Min.	8. Date of Bi (Month, D	lay, Year)	9. Bi	rthplace (State or Foreign ountry)
	ō		Usual Residence of Decedent						1	FEB.	10,	ISTIKIC	CHMOND, WV
	nylan show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits
	88-f	Director	D.C.		. W	ASHING	TON						X Yes 2 No
	with th	5	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What C	ountry?
	a 23	Funeral	1503 GALES ST.		-4	0 100	20002					TED STA	
	ter d	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed Fo	edent Ever in U proes?	.5. 13.	Was Decedent of f Yes, specify Cu	Hispanic Oi Iban, Mexica	irigin? (Spec an, Puerto R	cify Yes or N Rican, etc.)	0-	 14. Race - Am Black, Whi 	
980	urs al	by	3 Widowed 4 Divorced		ve		1□Yes 🌠 N	o Specify	y:			Specify: BI	ACK
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itema 23a or 28e-f ahow avent, Ira Modical Exerting transite notified at	Completed	15. Deceden	it's Education		16a. Dece	dent's Usual Occ	upation			16b. K	ind of Business	s/fndustry
2121	within and the street of the s	nple	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of work don DO NOT use retii	e during mo: red)	st of working	g			•
	filed w Hygien other th	ပ္ပ	8th						ICIAN		_	RIVATE	
and		Be	17. Father's Name (First, Middle,	Last)						(First, Middle	e, Maiden	Sumame)	
Maryland	should be nd Mental marked o	10	FRED KENT	W. C D. O.		T			IA KE				
Z	nd 2 si lith an 27 is r		19a. fnformant's Name/Relations MARJORIE HYSON				g Address (Street						Zip Code) 20002
อ์	Tegen The		20a. Method of Disposition	ONOGITER	20b. P	Place of Dispo	sition (Name of	- T	Da			ocation - City or	
ē	m O		1 ABuriat 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from	State	emetery, cren	natory or other p						
altimore,	permit. Page Department Importent: If any Injury o		21. Sigrature of Funeral Service	-	F.	4 4	LN CEMET . Name and Add		10-1		1	NTWOOD, UARY IN	
m	Page 2		DAMAN (THAT	K. Ha	I Va	425 MARY						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	aused the death	h. Do not ent	er the mode of dy	ing, such as	s cardiac or	respiratory a	arrest,		Approximate
e.	Physician		Immediate Cause (Final disease or condition	SE	505	15						-	Interval Between Onset and Death
# F	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							- weeks
1	Cxammer		Sequentially list conditions,		ンナーマ		Dec	ا ، و ب	NI	010	ens		months
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68760	ficate be executed physician and s the burial-transit	alE			,								
_		edical		Q									
ROX	it the death certif by the attending tached for use a	Physician/M	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna		<u>.</u>				2	23d. Date of del	livery
	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Ectopic pregnan Other (s <i>pecify</i>)	су				Month	Day Year
J.	at the	Phy	9 Unknown										
Š	law requires that the death certi as been signed by the attending 2 should be detached for use a	þ	Part If. Other significant condition	ons contributing to de			derlying cause g	iven in Part I	l.				the cause of death?
Hecords,	w require been sig should b	Completed	1 copies at the	341 (014	Ven		(AL 196	penu	and .	10	Yes 2[JNo 3□Pr	obably 4 Unknown
ě	e law has t	ğ	UNSHE C. F.	ed Lun	5 414		ENCERSL	a lope	ally	24a. Was auto	psy	24b. Were au	topsy findings available completion of cause of
	sician: The la certificate ha irector, page 3		Cenesal	Linfa	initie	2.2				1 Yes	rmed? 2XX No	death?	2 🗆 No
VITA	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	/		_ 0:	han		Check only o			
0		-	27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Inju	4 L NI		e 5 ☐ Reside. Describe I		Other (Spec	cify)
0	Attending Pher death.	atlo	1 Avatural 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year)	Injury	W	onk?]Yes 2.∐				, 00041100	
DIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of fnjury - At ho	me, farm, stre	et, factory, office		28	f. Location (Street and	Number or Ru	ıral Floute Number,
5	rs after on selection of the control	Cer			ng, etc. (<i>Specily</i>	′)				City or To	wn, State)		
	Hospl 4 hou Funer ely fill	edicai	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the ba	best of my know	wledge, death	occurred at the t	me, date an	nd place, and	d due to the	cause(s)	and manner as	stated.
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the to	Med	one) 29b. Signature and title of certifier										
	F ₹ 5 8		250. Signature and title of certifier	an an	1. 8	1	29C. Licen	se number	-		29d. Date	signed (Monti	h, Day, Year)
	2		30. Name and address of person	who complaint	a of door "	020) (7	2	16	7 5		UCT	المهما	נשטי ו
	0		Paul A A	VORE MA	Y 2012	(Q)	29c. Licen 2 Crint) Pensbury	v Rd	HUGO	ithis	,110	MD Z	1018
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ture	0 .	,		12 -	- 110		
-c, -s	Registr	ar	0CT 1	4 2005	4000,000	B 4	booke						

CT05-06885 Bandy, Bradley **Physicia** /Medic Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event. The Medical Examinational Examination once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental I

Hygiene Reg. No.	0	0	5	3	3	2	8	
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29d. Date signed (Month, Day, Year)

October 10, 2005

111 Penn Street Baltimore, Maryland 21201

T = State Registrar		Certif	ficate of L	Death		Rec	2 U C	, ,	0061	00
1. Decedent's Name (First, Middle, Last,					. Date of Death	Date of Death 3. Time			Death	
Bradley Michae	1 Dander					October	Ö9	2005	6:17	DIM
4a. Facility Name (If not institution, give	street and number)	41	b. City, Town, or	Location of		october.	4c. County		0.17	LFI
						,				
Bradshaw Road @ At 5. Social Security Number 6. Sec		ast birthday) If	Kingsv Under 1 Year	II Under 2	4 Hrs. g	. Date of Birth	Ba	1timor	ce (State or	Comina
*E	^{™ 2□F} 28		lonths Days	Hours	Min.	(Month, Day, Y		Countr	TY)	roreign
Usuat Residence of Decedent					М	ar. 16,	1977	Mary	land	
10a. State 10b. County	10c. City	, Town or Locati	on					100	d. Inside City	/ Limits
Maryland Hanford									1 ☐ Yes 2	2 ANo
Maryland Harford 10e. Street and Number	<u>E</u>	<u>dgewood</u>	10f. Zip Code			100	Citizen of I	4/h	0	
	D.					100	g. Citizen of V	vnat Countr	y r	
1560 Harford Sq				040			1	SA		
	12. Was Decedent Ever in U.S Armed Forces?	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				y Yes or No- can, etc.)	No- 14. Race - American Indian, Black, White, etc.			
1 XNever Married 2 Married	1 ☐ Yes 2 💽 No If Yes, Give	10	1 ☐ Yes 2 ☑ No Specify:					Specify:		
3 Widowed 4 Divorced	Year or Dates:			1110			Opociny	Whi	ite	
15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Decedent (Give kind	's Usual Occupa d of work done o	ition luring most (of working	16	6b. Kind of Bu	ısiness/Indu	ıstry	
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired)	3					
12		Carpen	ter				Constr	action	1	
17. Father's Name (First, Middle, Last)				18. Mother	's Name (F	First, Middle, Ma				
Richard Lee Dorma	an			Susa	n Aı	nn Band	7x7			
19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing A	ddress (Street a			Route Number, (State, Zip C	Code)	
Susan A. Dancy / Mc	other					., Edgev				
20a. Method of Disposition	20b. Pla	ace of Dispositio	in (Name of		Date	20	c. Location -	City or Tow	n State	
1 ☐ Burial 2 ☑ Cremation 3 ☐ R	Removal from State	metery, cremato	ory or other place							
4 Donation 5 Other (Specify)		ltop Sei					wson,	Mary	and	
21. Signature of Funeral Service License	7/	McC	omas Fu	s of Facility Ineral	Home	P.A.				
Sigles (11)	elegy	131	l7 Cokes	bury	Road,	Abingo	lon, Ma	irvlan	d 2100	09
23a. Part1. Errier the disease, or compli- shock, or heart failure. List only or	cations that caused the death.	Do not enter th	ne mode of dying	, such as ca	ardiac or r	espiratory arrest	,	A	Approximate nterval Between	
Immediate Cause (Final disease or condition	hurino tomories								Onset and De	
resulting in death)	Due to (or as a conseque		10003							
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a conseque	ence of):								
cause. Enter Underlying Cause (Disease or injury										
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c. Due to (or as a consequence of): d.										
	J						_	_		
IF FEMALE:										
23b. Was decedent pregnant 2	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal or		opic pregnancy				1.0	e of delivery		
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		ner (specify)				Mor	ith D	ay Ye	ar
9 Unknown										
Part II. Other significant conditions con	tributing to death but not result	ting in the under	lying cause give	n in Part I.		23e. Did tobac	co use contr	ibute to the	cause of dea	ath?
						1 🗆 Yes	2 No	3 Probab	oly 4 Uni	known
					_	04-145	1			
						24a. Was an autopsy	P	rior to comp	y findings av- pletion of cau	ailable se of
						performe	d? d	eath?	□No	
25. Was case referred to medical examiner?				26. Place o	f Death (C	check only one)				
1 X Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ E	P/Outpatient 3	DOA Othe	_		5 🗌 Residend	e 6 XIOthe	er (Specify)		
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work			. Describe how				
1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	18:128	PM 1 □Yes 2 VNo		/				G ₁	
3 ☐ Suicide 6 ☐ Could not be			et, factory, office 2			DRIVON OF VEHICLE WENT INT 28f. Location (Street and Number or Rural Route Number				10
4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)					City of Town, State)				MM
29a. Certifier 1 ☐ Certifying Phys	I CODY W			4-1		ADS MW R		SUTUSPI	onatio	00000
(Chock only ZX Medical Exaiting	sician: To the best of my know	neage, death occorn and/or investa	gation, in my op	e, date and ; inion, death	place, and occurred	due to the caus at the time, date	e(s) and mai and place, a	ner as state	ad. ne cause(s)	
one)	and manner stated.						,			

State

Registrar

within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

OCT 1 4 2005

29b. Sigmature and title of certifier

1602451 32. Registrar's Signature 29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene 33284 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 12, 2005 **Physician** KATHERINE J. BALDWIN 12:15 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 113 KENT ROAD GLEN BURNIE ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | NOV 23; 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 M 2 F Months WEST VIRGINIA 213-32-9190 68 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28e-f ehow treumetic event, the MacLeal Examinar must be notified at 1 ☐ Yes ŽŽ No MARYLAND ANNE ARUNDEL GLEN BURNIE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be tiled within 72 hours after death with 1 ment of Health and Mental Hygiene. sut: If item 27 is marked other then "natural", or iteme 23s or : 113 KENT ROAD 21060 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOSTESS FUNERAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WOODROW KENNEY MARY L. CRABTREE 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l WANDA BALDWIN / DAUGHTER 10319 F MALCOLM CIRCLE COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition OCT. Dales, 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. GLEN HAVEN MEM. PK. 2005 GLEN BURNIE,MD 4 □ Donatjen 5 □ Other (Specify) 21. Signatu Funeral Service Licensee KIRKLEY KUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** C disease or condition resulting in death) /Medical Due to (or.as.a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No Records, P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 2 No 1 Yes Division of Vital To the Hospitet or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) 2XX\0 1 🗌 Inpatient 2 1 Yes 2 ER/Outpatient 3□ DOA this Atter thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XX atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation nerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Dire 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D41197 OCTOBER 12, 2005 1)1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h SAMUEL MILLER, M.D. 1406 S. CRAIN HWY. GLEN BURNIE, MD 21061 SUITE 200 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra OCT 1 4 ZUUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 5 33285 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Genevieve October 10, В. 2005 9:45P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cockeysville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Maryland Masonic Home Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F **Director** 217-18-5548 82 Aug 30, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner coust be notified at 1 ☐ Yes 2 No Baltimore Maryland Cockeysville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 03 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 7 is marked of and Mental Brundick Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health a rtant: If itam 27 is njury or other tra Renee Fries/Daughter 14410 Katie Road, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: eny injury c once. ⁴ 4 ☐ Donation Comfort Crematory 10/14/05 | Alexandria Virginia Mt. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 21. Signature of Kingra yice Licens Bryan W. Clary 23a. Part 1. Enter the disease, or complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each li e. Immediate Cause (Final disease or condit resulting in death) Stage Dematin Priysician /Medical Due to (or as a consequence of): Examiner A Mer 100 cular. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ arter 1 Yes 2 No 3 Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ Ño 24a. Was an has autopsy performed? certificate 1☐ Yes 2☑No of Vital : After this certification of the things of 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after decreal Director: After Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 - Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

ROBERT 21BERTU, 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Bank

29c. License number

D21464

Balto, Mul 21227

29d. Date signed (Month, Day, Year)

10-12-05

State of Maryland / Department of Health and Mental Hygie 2005 33286 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Gladys October May 11, 2005 2015 Sleeth Chiellon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M ¾□ F Yrs. Director 81 512-12-7841 4, Kansas Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Carroll Westminster Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Locust Street Apt 705 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 ie marked other then 'any injury or other treumatic event, the Metan injury or other treumatic event, the Metan injury or other treumatic event, the Metan injury or other treumatic event, the Metan injury or other treumatic event, the Metan injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Ear1 Sleeth Gladys May Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mrs. Sharon Ann Johnson Zelefsky 9 Jessie Court Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 10/15/05 Reisterstown, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses once In Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** boal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due Examiner Andievoscular Mistra The law requires that the death certificate be executed as the burial-transit 12 ming 2 that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ō Month 4 Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2-2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☑ No certificate 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2/2 No 1 Dinpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1- Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medicai 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) trigen mo 2018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Hensgen 410 Malcolm Dr. Suite C, Westminster, MD 21157 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar OCT 1 4 2005

			1 - For State Registrar	State of Mary	land / Depa	artment of Health a	and Mental H	lygiene Reg. No	2005	33287		
			1. Decedent's Name (First, Middle, Last)				2. Date of Month			3. Time of Death		
	Physici /Medic		ALEXANDER CI	ARKE			OCTORI		y Year 7, 2005	6:08 A ^M		
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of	of Death	40	. County of Death			
			LAUREL REGIONAL HO 5. Social Security Number 6. Sex		yrs. last birthday)	LAUREL	24 Hrs. 8. Date of I		RINCE GEO			
	"natural", or items 23a or 28a-i show and coloral Examinar must be notified at			M 2 F	84 Yrs.	Months Days Hours	Min. (Month,	e of Birth nth, Day, Year) -20-1920 9. Birthplace (State or Foreign Country) LIBERIA				
			Usual Residence of Decedent				12-2()-192		- 12-2		
		_								10d. Inside City Limits 1 Yes 2 No		
	28a-f	Director	Md Montgomery 10e. Street and Number		GERMANI	10f. Zip Code		10a Ci	tizen of What Cou			
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	ms 2%	Funeral		12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispanic Orig	gin? (Specify Yes or		14. Race - Ameri	can Indian,		
9	or ite	匝	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		f Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:	, Puerto Rican, etc.)		Black, White,			
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yla	2 should be and Mental is marked o	2	ROBERTSON CLARKE				VA WATSON					
Maryland	12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship (Ty) ERIC CLARKE/SON	oe, Print)		ng Address (Street and Numbe 2 STONE HOLLOW				0874		
	ss 1 and 2 should of Health and Men item 27 is marke t other traumatic		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of	Date Date	_	ocation - City or To			
Baltimore,			1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	-	natory or other place) HEAVEN CEMT . 1	0_22_05		VER SPRII			
Ħ	그 돈 뿐 글		21. Signatur Funeral Service Loinse		11 2	2. Name and Address of Facility				TUARY INC.		
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			23a. Parl1. Enter the disease, of compli shock, or heart failure. List only or	cations that caused the e cause on each line.	death. Do ot ent	er the mode of dying, such as	cardiac or respiratory	arrest,		Approximate Interval Between		
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/	C cause Fates Undertying											
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Νį		ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		(Street an	nd Number or Rura a)	al Route Number,		
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	ner: On the best of manner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the hoccurred at the tim	e, date and) and manner as s d place, and due to	tated. o the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier			29c. License number		l	te signed (Month,			
,	0		1 H 1000	here un	>	D 23181		OCTO	OBER 8, 2	2003		
_	.7	10	30. Name and address of person who co	704 GORMAI	N AVE,	# T-1 LAURE	L , MD 20	707				
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 4 20	32. Figistrar's	Signature	parti						

	Please Type or Print in Black State of Maryland / D 1 - State Registrar 1. Decedent's Name (First, Middle, Last)	r Indelible Ink. Ensure A repartment of Health and Certificate of Death	All Copies Are Legible. Mental Hygien 2005 33288 Reg. No. 3. Time of Deathy			
Physicia /Medica Examine	ROBERT CARTER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deal	SEPTEMBER 19, 2005 11:58 N			
Funeral Director	PRINCE GEORGE'S HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	CHEVERLY If Under 1 Year If Under 24 Hrs	PRINCE GEORGE S 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig			
D	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location ·	JUNE 21, 1952 WASHINGTON, D 10d. Inside City Limits WYes 2 No.			
within 72 hours after death with the Maryland liene. rthen "naturel", or Items 23a or 28a-f show Ite Medical Executant Execution at	10e. Street and Number 1827 CORCORAN ST. N.E. #1 11. Marital Status	10f. Zip Code 20002 13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puer				
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be filed at Hyg of othe event,	17. Father's Name (First, Middle, Last) CLARENCE CARTER	18. Mother's Na	me (First, Middle, Maiden Surname) JOHNSON JURAI Route Number, City or Town, State, Zip Code)			
permit. Pages 1 and 2 should Depertment of Health and Mer Importent: If Item 27 is marke eny injury or other treumatic once.	20a. Method of Disposition 20b. Place of cemeters 20b. Place of cemeters	Disposition (Name of community or other place) COLN CEMETERY 10- 22. Name and Address of Facility	TEMPLE HILLS, MD 20784 Date 20c. Location - City or Town, State 1-05 BRENTWOOD , MD CAPITOL MORTUARY INC., N.E. WASHINGTON, D.C. 20002			
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igne bed	Part II. Definer significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
Physicien: The farthis certificate hes	25. Was case referred to medical examiner?		24a. Was an autopsy performed? 1 \(\text{Yes} \) 2\(\text{No} \) No 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2\(\text{No} \) No ath (Check only one)			
	2 Accident investigation 3 Suicide 6 Could not be determined determined	me of ury 28c. Injury at work? M 1 Yes 2 No	tome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,			
5 5 6 6 C	29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and and manner stated.	city or Town, State) a, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)				
To th within To th	29b. Signature and title of certifier	29c. License number D58 95 1	29d. Date signed (Month, Day, Year) 9-22-05			
State	30. Name and address of person who completed cause of death (Item 23a) (JR JAKY LITTLE 3001 HoSP 31. Date filed (Month, Day, Year) 32. Begistrar's Signature OCT 1 4 2005	Type, Print) ITAL DRIVE (9-22-05 HEVERLY, MD 20185			
Registra	OCT 1 4 2005 Brew &	Sperli				

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carbotti Month Day Year **Physician** 20:30M Marie 2005 Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Months Days Hours Min. S. Date of Birth (Month, Day, Year) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Yrs Director 061-01-9995 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits od other than "natural", or Iteme 23a or 28a-f show event, I've Medical Exemples must be notified at 1 X Yes 2 □ No Montgomery Gaithersburg Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 217 Booth Street, #306 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Eventence. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fashion Designer and Pattern Maker Clothing Manufacturer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rocco Cancellare Celeste Pierri 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19909 Mastenbrook Place Moutgomery Village, Maryland 20886-1341 Patricia S. Wright / Daughter Montgomery 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) October 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 M01433 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician**)cpsis hrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) the a detached 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sign page 2 should be intestinal obstruction secondary to large pelvic mass 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 K No vine Hospital or Attending Physician: Th within 24 hours after death.

To the Funeral Director: After this completely filled in the funeral Director. 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Alnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 61549 Lepouhe 2005 ()c1 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Lepoutre, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deneva & OCT 1 4 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 0 0 5 33290 State
Registrar Amend Item 196 Per FH G849 10 FOLL CONTROL OF CONT Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CARMELLA MARY DUCK October 11, 2005 8:35 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosa Nursing Home Mitchellville
Under 1 Year | If Under 24 Hrs. Prince George's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex Birthplace (State or Foreign Country) Days Months Hours Min 1 ☐ M 2 🖾 F 90 Director 10, Italy Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Lottsford Vista Road 20721 Completed by Funeral U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Yes, Give ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene. 7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angelo Pometto Jennie Strazza 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Bural Boute, Number 217 Bowie, Md. 20716 Pages 1 and 2 s ment of Health an of Health itam 27 Robert F. Duck - Spouse 501 Main Street, Apt. 331, Laurel, Maryland 20707 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/14/2005 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 Dascholanning 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 kg disease or condition resulting in death) /Medical consequence of) Examiner ement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Due to (or Examiner The law requires that the death certificate be exec burial-1 Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Aq. 1 Tes 2 No 3 Probably 4 NUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 X No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4K Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To tha Funerel C 29a. Certifie 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha 29b. Signature tle of certi 29c. License number 29d. Date signed (Month, Day, Year) ind 2261 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person you Richmy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 33291 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 **Physician** 102005 Betty Dreislein 08:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 506 Callendar Street Baltimore N/A If Under 1 Year If Under 24 Hrs. Social Security Number 216-20-4772 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 11-03-1923 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🛭 F 81 Director Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f ahow traumatic evant, the Mudical Expedities has be notified at MD N/A 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Callendar Street 21230 or Itams 23a U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. it. Pages 1 and 2 should be filed within 72 hours after imment of Health and Mental Hygiene. Intent: If item 27 is marked other than "natural", or Item 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 TriDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Tremor Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jessie Turner/Family Friend 2001 Bear Ridge Rd. Apt 201 Baltimore MD 21222 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery njury o 10-18-2005 Brooklyn, MD ` 4 ☐ Donation 5 ☐ Other (Specify) permit.
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any inju 2. Name and Address of Facility
Imbrose Funeral Home of Lansdwone
719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Si pature of Funeral Senne 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Do not enter the mode of dying, such as cardiac or respiratory arrest, cations that caused the death. he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medica IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 🗆 No 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide after 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0007309 10/10/00 munsque 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 Potee St BAHD. Md. 21225 SILVINO B. MUNESES 32. egistrar's Signature 31. Date filed (Month, Day, Year) 1 4 2005 Registrar

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.O. Box	thet the death certifined by the attending to detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal o	death 3	Ectopic pregr Other (specif					23d. Date of de Month		Year
S, D	equires en sign	þ	Part II. Other significant condition	s contributing to death b	out not result	ting in the ur	derlying caus	e given in	Part I.			use contribute to	o the cause of d	
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)			30. Name and address of person w	he ya	ell (Itam 3	W) (Type 1	Print)	o.c.	M.E.		Octo	ber 10,	2005	
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	/Medic Examin		4a. Facility Name (If not institution, g		mber)		4b. City, Town, or	Location of Death		4c. County of Death		
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36	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "naturel", or Items 23e or 28e-f show event, the Medical Evarinar must be rigitied at event,	by Funeral	1 Never Married 2 Married 3 Warried 3 Warried	Armed For 1 Tyes If Yes, Gir Year or D	2 1X No		if Yes, specify Cuba 1 □ Yes 2 🕱 No	n, Mexican, Puert Specify:	o Rican, etc.)	Black, White Specify: Wh	_	
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H	Physician		Immediate Cause (Final disease or condition	a.Chack	ue ol	B-HAU	ctive &	Ulwerra	AX PI	sease.	Onset and Death	
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Вох	death certifi e attending d for use as	ian/	23b. Was decedent pregnant in the past 12 pronths?	1☐Live b	come of pregna pirth 2 Fetal	Idéath 3□	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year	
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σ.	that hed by deta		Part II. Dther significant conditions	contributing to d	eath but not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?	
rds,	requires that een signed b nould be deta	ed by	- oseopor	20515	-	- 22			1 Yes	2 No 3 Prol	bably 4 Unknown	
Record	> 40 10	Completed	- SQUAMOU	scel	CAR	CIAO	WA EX	the	24a. Was an		ppsy findings available	
Ä	0 4 6	mo:	e proffic					1145	autopsy performe 1 Yes 2 2		impletion of cause of	
Vital	ician: Th	Bec	25. Was cas eferrer to medical examiner?			20		26. Place of Dea	th (Check only one)	110		
of V	8 8	2	1 Yes 2 No	Hospital: 1 🗆	npatient 2	ER/Outpatier	t 3 DOA Othe	4 Nursing H	ome 5 Residenc	ce 6 Other (Special	(y)	
		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurred		
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Division	ol or Atten after deat I Director: d in by the	ertification;	4 Homicide determine	buildi	ng, etc. (Specif)	nne, iaim, sii /)	eet, factory, office		City or Town, S	et and Number or Run State)	ar Houle Number,	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only 2 Medical Ex	Physician: To the	best of my known	wledge, death	occurred at the tim	e, date and place	, and due to the caus	se(s) and manner as s and place, and due to	stated.	
	thin 24 thin 24 the F mplete	Medi	one) 29b. Signature and title of certifier	and man	stated.	norr and or m	29c. License			//	Day, Year)	
	F B F 8	-) CIV	18/	en		D25	33/	10	0/11/200	5	
	12			o completed caus	Dec. 1	23a) (Type,	Print) 760	o osle	R DAYN	e suff	e 311.	
	-0-		31. Date filed (Month, Day, Year)		egistrar's Signa	212	24	BRIC	Fishe	RUD		
	Sta Registr	-			ygistiai s Sigila	he A	and i					
			UC 1 4	2005	Mary 1	() ()						

			_ State	tate of Maryland /	Department of H	ealth and M			33295
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeani	2. Date of Death	J. No.	3. Time of Death
	Physici		0 , 0 ,	5 - 0:			Month	Day Year	- OLLA OM
	/Medic Examin		4a. Facility Name (If not institution, give street	et and number)	4b. City, Town, or	Location of Death	JCH Ober	4c. County of Dea	
Н	LAGITIII	CI	C11	Re-Franklin W		State		0	nore
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign
	Director		310-24-25041	2× 83	Yrs. Months Days		Februcey		ONSULVENICA
	and w		Usual Residence of Decedent 10a, State 10b, County	10c City Tox	wn or Location				10d. Inside City Limits
	Manyli f sho	ŏ	0.0						1 Tyes 25 No
	28a-	Funeral Director	10e. Street and Number	ore Yar	Kuille 10f. Zip Code		10	g. Citizen of What C	
	3a or	0	9510 Buston	Avenue	213	234		$t \in \Lambda$,
	death ms 2	nera		Was Decedent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spec	cify Yes or No-	14. Race - Am	
9	after or its	/Fu	1 Never Married 2 Married	Amed Forces? 1 □ Yes 254No If Yes, Give	1 ☐ Yes 2 🛣 No	Specify:	tican, etc.)	Black, Wh	ite, etc.
	be filed within 72 hours after death with the Maryland all Hygiene. I all Hygiene. I de thygiene. I de Medical Exacitrat for the notified all event, it a Medical Exacitrat for notified all	d by	3 Wildowed 4 Divorced	Year or Dates:	12.00	opoony.		Specify:	shite.
7	"nat	Completed	15. Decedent's Education (Specify only highest grade co	on 16a Impleted)	a. Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired.	lurina most of workin	g 10	Bb. Kind of Business	s/Industry
12	withi ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	menake		1	IL Was	ne
D	illed Hyg othan	BeC	17. Father's Name (First, Middle, Last)		Concention	18. Mother's Name	(First, Middle, Ma		
<u>a</u>	Alenta Alenta rked fic ev	To B	Harry GRill. S	R		Emma	Geh	Bis	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department of Hygiene 21 is marked of the than "natural; or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be nutilized at ORCE.		19a. Informant' Name/Relationship (Type,	Print) 19	b. Mailing Address (Street a	and Number or Rural	Route Number,	City or Town, State,	Zip Code) 21144
	and and in 27 m 27 mar tra		Sandra Cross-1	riece 19	30 Strwe C	astle DRI	vie Seve	m, Mary	and 1461
altimore,	Pages 1 nent of H int: if iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo	20b. Place comete	of Disposition (Name of ery, crematory or other place	e)	ate 20	c. Location - City	r Town, State
<u>=</u>	ment tant:		`4 Donation 5 Dother (Specify)		wxxd Cemele	Ry lock 15	- 2005 t		Maryland
Ba	permit. Depart Import any inj		21. Signature Funeral Service Licenser	11	22. Name and Addres	s of Facility	WIS CH	ispel of	memories
	40200		222 Part Enter the disease of complicati	Control to door Do	18800 HERE				no 21234
ŀ			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.	. not enter the mode or dying	j, such as cardiac or	respiratory arres	ι,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	metastatio		ancer			4 months
	Examiner			Due to (or as a consequence	o of):				
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/	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events c.						
o	e exe ian ar irial-t	ËX	resulting in death) Last	Due to (or as a consequence	of):				
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d						
9	ertific ding p	Med	IF FEMALE:	If yes, outcome of pregnancy					
Box	eath certific attending pl	Physiclan/Me	in the past 12 months?	1 DLive birth 2 DFetal death 4 DPregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	elivery Day Year
o.	the di y the iched	ysic		9 Unknown	3 🗆 Other (specify)				
a.	res that the de igned by the a be detached t	by PI	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying cause give	n in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rds	w require been sig should b						1 ☐ Yes	2Æ No 3□P	robably 4 DUnknown
Records,	aw re	Completed					24a. Was an	24b. Were a	utopsy findings available
	: The fav cate has page 2	Com					autopsy performe	d? death?	completion of cause of
Vital	ysician: is certific director,	Be (25. Was case referred to medical examiner?			26. Place of Death	<u> </u>		
_	Physic this or	70	1 ☐ Yes 2 No Hosp	1 Inpatient 2 ER/O		4 X Nursing Hom		ce 6 □Other (Spe	ecify)
U O	ding P	lon	1 Natural 5 ☐ Pending		Time of Injury Work		3d. Describe how	injury occurred	
ISIC	Attandi death. ctor: A y the fu	lcat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, f.		'es 2 □No	Rf Location (Stre	et and Number or R	ural Route Number
Division of	after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	am, anda, laday, allos		City or Town,		arar route (variber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification principle in by the funeral director, and the funeral director, and the funeral director, and the funeral director, and for the		29a. Certifier 12 Certifying Physicia	in: To the best of my knowledg	e, death occurred at the time	e, date and place, ar	nd due to the cau	se(s) and manner as	s stated.
	n 24 n 24 he Fu	Medical	(Check only 2 Medical Examinar:	On the basis of examination as and manner stated.	nd/or investigation, in my op	inion, death occurred	d at the time, date	and place, and due	e to the cause(s)
	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Σ	29b. Signature and title of certifier		29c. License	number	290	. Date signed (Mont	th, Day, Year)
	7		Plorence Ve	com ca Deg.	ng Doc	5134	5 P	ctober 13	3,2005
	10		30. Name and address of person who compl	eted cause of death (Item 23a)	(Type, Print)	. 7. 0		- 0 11	. 4/2 2 222
			31 Date filed (Month Day, Year)	MD 9101 F	Tankin Squa	un s	NHC 204	5 BOUTH	NU MUSZ/25)
	Sta Registr	31.1	31. Date filed (Month, Day, Year) OCT 1 4 2005	eted cause of death (Item 23a) My 9101 F 32 Registrar's Signature	good				

			For				lealth and Me	ental Hygi	iene	22206
			- State Registrar Amend Item	#8 Per FH	G849 1176	stificate of I	Death		2005	33296
	Physicia		1. Decedent's Name (First, Middle, La Rose Emily	st)				2. Date of Death Month	Day Yeer	3. Time of Death $945 \rho_{\rm M}$
	/Medic Examin	1,2%	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
		-in	Franklin Squ		spital	Rose	dare		Baltin	nore
	Funeral Director		5. Social Security Number 151-30-7274		e (In yrs. last birthda) 68 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birty Sept 2	9. Bi	rthplace (State or Foreign aryland
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryle f sho	ō		imore		Essex				1 ☐ Yes 21€ No
	the l	rect	10e. Street and Number		1	10f. Zip Code		10	og. Citizen of What C	country?
	h with	a D	330 Georgia A	ve.		21	221		USA	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f show ha Madical Examinat ribat be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 14 17 19 19 19 19 19 19 19 19 19 19 19 19 19		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh SpecifyWh:	ite, etc.
9-0	72 hou	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	ation during most of workin	na i	16b. Kind of Business	s/Industry
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, Ira Modical	nple	Elementary/Secondary (0-12)	College (1-4or s	life	DO NOT use retired memaker	d)	9	own home	e
	filed w Hygier other th		9th 17. Father's Name (First, Middle, Last	.)	110	memaner	18. Mother's Name	(First Middle N	Maiden Sumame)	
anc		To Be	Richard And		s Sr	ı			e McBrid	de
Maryland	s 1 and 2 should be filed within F Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ita M.	F	19a. Informant's Name/Relationship						City or Town, State,	
Baltimore,	ages 1 and 2 nt of Health If Item 27 or other tra		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 [20b. Place of Dis	position (Name of ematory or other place IIICemet			20c. Location - City o	
탪	permit. Pages Dependent of H Important: If Ite any injury or of		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		01	22. Name and Addre	ss of Facility	anollest	Z	omeofEssex
Ba	Departing Important		* K. Tell	Monn	elly		COI		timore M	
			23a. Parti. Enter the disease, or con shock, or heart failure. List only	aplications that caused	the death. Do not e					Approximate Interval Between
V.	Physician		Immediate Cause (Final disease or condition	7 Obst	ructive	Pno	eumoni	0.		Onset and Death
	/Medical Examiner		resulting in death)	a	a consequence of):					
ł	Examine	_	Sequentially list conditions.	b. Lung	a consequence of):	ose				The days
	ted usit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D06 10 (0° a3	a consequence or,					Two Days
K.	icate be executed physician and s the buriat-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	1				Two Days
87608	ysicia e buri	dical		_ d.						
9	ng ph as th	Φ	IF FEMALE:							
D. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	B⊟Ectopic pregnancy □ Other (specify) _	/		23d. Date of de Month	alivery Day Year
P.0	uires that the de n signed by the a id be detached f		Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	luires rign rid be	Completed by	Dementia	, Rer	ial fo	ilure		1 ☐ Ye	s 2 0 √ 0 3 □ F	Probably 4 Unknown
00	w require s been si shoutd I	lete						24a. Was ar		autopsy findings available
Re	The la te has	mo						autops perform	ned? death?	completion of cause of
ita	sician: The law certificete has b lirector, page 2 s	BeC	25. Was case referred to medical examiner?				26. Place of Death			
)	Physician: r this certifice ral director,	To E	1 Yes 2 No	Hospital: 1 Inpati			4 Nulsing Hon	ne 5 🗆 Reside	ence 6 Other (Sp	ecify)
0	Ing Pl		27. Manner of De th 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injury	Wor		8d. Describe ho	w injury occurred	
sio	tendi Jeath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not	-	iun. At hamo form		Yes 2 □No	ISI Location (St	reet and Number or F	Pural Poute Number
Division of Vital	lor At efter d Direction by	Certification:	4 Homicide determined	2.00. Flace of III	jury - At home, farm, tc. (Specify)	street, ractory, office		City or Town		tural mobile reamber,
_	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C		hysician: To the best miner: On the basis of and manner st	of examination and/or					
	o the	Me	29b. Signature and title of certains	2.10 1.1011101 31		29c. Licens	se number	25	9d. Date signed (Mor	oth, Day, Year)
			16 18	MD		000	63011		10-11-	2005
7	3		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)			`	
200			DR Geraid Bloc	mfield	9000 Fran	nklin Squ	are Drive	Balt	more 1	10 7123 +
ě		ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1				
0.1	Regist	8	061 [4	± ZUUD	die St.	House				
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DHMH 17 Rev 1/2001

Elliott, Rose

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 33297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Fendlay 1:3 6AM 2005 James Octuber /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Baltimore City Johns Hopkins 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign
 Country) **Funeral** 1 M 2□F Yrs. 214-360-Director Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is markad other than "naturel", or items 23s or 28s-f shov other treumstic avent, the Medical Examinar must be notified at 1 Yes 2 No Hartor Baldwin Directo 10e. Street and Number 10g. Citizen of What Country? 21013 13819 USA ane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ottery Commission Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Heelth ar Important: if item 27 is any injury or other trau once. MD Hicks Kd. atherine Flanagan-Cousin 1600 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility OEK RD Timonium MD 21093 Marle. REACEFUL ALTERNATIVES FUNERALSCREMATION CENTER Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on ations that 23a, Part 1. Enter the diseas death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death daused the Immediate Cause (Final disease or condition resulting in death) neumocystis Preumonia **Physician** One Week /Medical Examiner Small Ceil Lung Cancer NOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, r use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 ☐ Fetal death in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2/1 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Brad Scitton, The Johns itopkins Itospital, 600 North Wille Street, Baltimore, maryland 21387 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		4	1 - For State Registrar			of Ma	ryland	/ Depa	rtment of F	lealth and N Death		Reg. No.			
L	Physicia /Medic		1. Decedent's Name (First, I Pauline A								2. Date of De Month October		2005 Year	3. Time of De 12:15	a M
	Examin		4a. Facility Name (If not insti	tution, give	street and nu	m <i>ber)</i>			4b. City, Town, o	r Location of Death)	4c.	County of Death		
2.	Funeral Director		5. Social Security Number 181–18–6858	6. Se	x] M 2[X F	7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	June 09,	th 1922	9. Birth	nplace (State or F ISYI vania	-oreign
	land ow	}	Usual Residence of Deceder 10a. State 10b. Co				10c. City, 1	Town or Lo	cation					10d. Inside City Limits	
	e Mary	ctor	Md. Bal	timore			Baltin	ore						1 ☐ Yes 2	ŬNo
	h with th	ai Dìre	10e. Street and Number 6628 Loch Ra	ven Bl	v d.				10f. Zip Code 21239			10g. Citi	izen of What Co USA	-	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itema 23e or 28e-f ahow amply injury or other treumatic event. The Modical Exercipar court be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 🔼 Ni ve	ver in U.S.		Vas Decedent of H Yes, specify Cuba □ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White Specify:		
altimore, Maryland 21215-0036	within 72 ho ene. than "natur ne Modical	Completed	15. Dec (Specify only h Elementary/Secondary (0- 12	1	ication le <i>completed)</i> College (F)	(Give	lent's Usual Occup kind of work done DO NOT use retired Inch Operat	during most of won d)	king		ind of Business/l	ndustry	
land 2	uld be filed Aental Hygir rkad other tlc event, I	To Be Co	17. Father's Name (First, Mi	idie, Last)						18. Mother's Nam Elizabeth		Maiden	Sumame)		
Mary	id 2 shoilth and h		19a. Informant's Name/Rela			ļ			-	and Number or Ru B lvd. Balt		-		ip Code)	
imore,	Pages 1 arment of Heal ant: If Itam; ury or other		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Oth			State	20b. Plac cem Dular	se of Dispo- letery, cren ney Val	sition (Name of natory or other place) ley Mem. G	dns. 10-17	Date 7–05		nonium, Mo		
Balt	permit. Departr Imports any inji		21. Signature of FurrerahSe	Vice Licens		4		² F	kuck towson .050 York R	รัศน์ก็อักสั่ว Ho d. Towson,	me, Inc. Md. 21204				
6	Physician and //Medical Examiner and state prevented its prevented and state of the prevented and stat	edical Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e, or comp List only o	a	(or as a	the death.	enf nce of):	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate interval Betwee Onset and De:	
.O. Box 6	death certi le ettending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	н		birth 2 nant at t	of pregnanc 2 Fetal de time of deat	eath 3	Ectopic pregnancy	/			23d. Date of deli Month	very Day Yea	ar
a	sign d be	b	Part II. Other significant co	AV	,		t not resulti	-	nderlying cause giv	ren in Part I.	23e. Did t		1.7	the cause of dea	
of Vital Records,	The ate h page	Completed											prior to death?	opsy findings ava ompletion of cause 2 No	ailable se of
	ding Physician: th. Atter this certific funeral director,	tion: To Be		17	28a. Date			VOutpatien Bb. Time of Injury	28c. Injur Wor	y at	ome 5 Resident Reside	dence	1	mHospi	ice
Division	el or Attending s efter death. i Diractor; Atte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Plac build	e of Inju ling, etc	ry - At hom. . (Specity)	e, farm, str	eet, factory, office		28f. Location (: City or Tox	Street an wn, State	d Number or Ru)	ral Route Numbe	r.
	To the Hospitel or At within 24 hours efter d To the Funeral Diracl completely filled in by	edical C	29a. Certifier 1 Ce (Check only one) 2 Me	tifying Phy lical Exam	rsician: To the liner: On the liner	pasis of	examination	edge, death n and/or inv	occurred at the tile restigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of c	auther /	my	Re	les.	un	29c. Licens	1905		29d. Dai	te signed (Month	Day, Year) 2, 2001	
	5		30. Name and address of pu	rson who o	ompleted cau	se of de	eath (Nem 2	3a) (Type,	Print) Char	Ceo St. 1	Ballo.	m	1 21	201	
	Sta Registi		31. Date filed (Month, Day,		32.	Registra	r's Signatur	feet							

DHMH 17 Rev 1/2001

FARBONE, PAULINE 10-13 05 @ 0015

State of Maryland / Department of Health and Mental Hygien 2 0 0 5 33299 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FROST JEROME **Physician** 11:48 AM 2005 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL MARYLAMD RINCE GEORGES SOUTHERN CLINTON 141 6. Sex 1 M 2 □ F tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 05 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 68 577-52-4119 Washington, D.C. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28e-f ahow 1X Yes 2 □ No Prince Georges Clinton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural, or Iteme 23e or ury or other treumetic event, the Medical Examiner must be a 8102 Highland Meadows Drive 20735 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Howard P. Foley Truck Driver Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Frost Daisy Wills ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8102 Highland Meadows Dr. Clinton, MD. 20735 Jerome Frost, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) George Washington 10-15-05 Adelphi, MD. 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 23a. Part I Inter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate terval Between ASPIRATION Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): HEART Examiner UNGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the ettending physicien and the for use as the burial-transit Po RIVS Hospital or Attanding Physician: The law requires that the death certificate be executed VRE that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTPERTEHSIOH 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown director, page 2 should & MO DIALY SIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient ပ 1 🗌 Yes 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in a property of the cause of examiners. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) D0061652 11/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATUL KATTAL, SUITE 750, 913/ PISCATAWAY RD, 31. Date filed (Month, Day, OCT 1 4 32. Registrar's Signature Year) State 4 2005 Registrar

DHMH 17 Rev 1/2001

			For State	State of Mar		partment of F <i>ertificate of</i> :				5	33300
			Registrar 1. Decedent's Name (First, Middle, Last	9		erincale or	Dealii	2. Date of Dea	Reg. No. ath		3. Time of Death
п	Physicia	an	_		taw, Jr.			Month Octobe	Day	Year 10.5	11:50A ^M
	/Medic Examin		Lawrence Pa: 4a. Facility Name (If not institution, give		Law, JI.	4b. City, Town, o	r Location of Death	00000	4c. County o		11.50A
	Examin	eı	Sunrise Assiste			Silver S	bring		Monte	omer	v
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h		ace (State or Foreign
	Director		217-34-7324	X M 2□F	67 Yrs	Worths Days	710013			Mary	,,
	pu >	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
	shor shor	5									1 ☐ Yes 2 No
	the N	Director	Maryland Montgo 10e. Street and Number	mery	Kock	ville 10f, Zip Code			10g. Citizen of Wi	hat Coun'	try?
	3e or	iΩ	11924 Shagbark Dr	1370		208	15.2		USA		
	ms 2;	Funerai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 1	Was Decedent of H If Yes, specify Cubi		ecify Yes or No			
9	tiled within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23e or 28e-f show ent, the Medical Examinar must be indiffed at	교	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	nicall, etc.)	Specify:	, White, e	AC.
21215-0036	urel',	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:							hite
2	"nati	Completed	15. Decedent's Ed (Specify only highest grad		16a. De	cedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Bus	iness/ind	ustry
2	withir ene. then	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+) 5+)	Teacher	-/		Educa	tion	
0	filed Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)			TCACHET_	18. Mother's Nam	e (First, Middle,	Maiden Sumame		
Maryland	ld be ental ked c	To Be	Lawrence	Furtaw			Mati]	_da	Roesn	er	
ary	shous and N s mar	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. M	ailing Address (Street	and Number or Rui	al Route Numbe	er, City or Town, S	tate, Zip	Code)
	and 2		Colin L. Furtaw/S	on		24 Shagbar				2085	
Ore	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other pla		Date	20c. Location - C	ity or To	wn, State
Ĕ	Pag ment ent:1	. 6	4 □Donation 5 □ Other (Specify)	Metro C	rematory	10/13	3/05	Catonsvi	.11e,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23e or 28a-1 show emportent: If item 27 is marked other then "naturel; or items 23e or 28a-1 show empty injury or other traumatic event, Ite Madical Examinat must be collised at ODGs.		Bryan W. Clar	Casa	•	Lemmon Fu 10 W. Pad	ess of Facility Ineral Hon Ionia Road	ne of Du	laney Va	.11ey 210	Inc. 93
	35		23a. Par 1. Enter the disease, or composition of the ck, or heart failure. List only	lications that caused to	he death. Do not						Approximate Interval Between
	Enysician	Ž.	Immedia Caus (Final disease or cant iton resulting in death)	. (Ortoli	o hul	menau	u W	lest	i i	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	7000	21 10 1 10 00	1			
	LAdiminei	_	Sequentially list conditions,	b. Due to (or se a	consequence of):					-	
4	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 23 a	consequence or).						
4	axecul and al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					-	
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical	· ·	d							
	tificat ig phy as th	0							-		
Вох	death certif e attending od for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 Ectopic pregnanc	v		23d. Date Mont		ry Day Year
	s deat he att ed for	sicie	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4☐Pregnant at ti 9☐Unknown		5 Other (specify)			Mon	JI	Day Tear
P.0.	res that the de signed by the a l be detached f	Phy	9 Unknown Part II. Other significant conditions o	entributing to dooth but	not regulting in th	a underlying cause au	on in Part I	23e Did t	obacco use contril	bute to th	e cause of death?
ŝ	signe d be d	l by	A I I MO	2 M/01	Milh	brun	Holosto	1		3 🔲 Proba	
ecord	iaw requires as been sign 2 should be	etec	- vary		(VA-)		- 400000	24a. Was	an 24h W	lare autor	osy findings available
Rec	The law ate has bage 2 t	Completed	V					autor	prosy prormed?	rior to con eath?	npletion of cause of
a		ပိ	25. Was case referred to medical	-			26. Place of Dea			☐ Yes	2 No
Vital	Physicien: this certifican ral director,	0	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outpa	atient 3 DOA Ott	200		dence 6 Other	r (Specify	ACCT LINE
1 of		n:	27. Manner Death	28a. Date of Injury (Month, Day	Year) 28b. Tim		ry at	28d. Describe	how injury occurre	d	7 4 3 3 7 4 97
Ö	Attending r death. ector: After by the fune	atio	1 Matural 5 Pending investigation				Yes 2 □No				
Division	- 0	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	, street, factory, office		28f. Location (. City or To:	Street and Numbe wn, State)	r or Rurai	l Route Number,
	urs af										
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 12 Medicel Exam	ysicien: To the best of niner: On the basis of a and manner state	examination and/o	eath occurred at the ti or investigation, in my o	me, date and place, opinion, death occur	red at the time,	date and place, a	ner as stand due to	the cause(s)
	o the	Me	29b. Signature and kitle of certifier			29c Licen	se number		29d. Date signed	(Month, i	Day, Year)
	⊢≯⊢ŏ		→			(614	7	101	1)/	01
•	1401		30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	pe, Print)	· V / ()		10/1	1	V 3
	101,		Nasreen Kango, M			pshire Ave	enue, Silv	er Spri	ng, MĎ	2090	4
		ate	31. Date filed (Month, Day, Year)	32. Registrar		1					
	Regist	rar	OCT 1 4	2005 //	· K	Coaste					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 33301 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Opie Foulkes 9:15 a M October 12. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6313 Deer Park Rd. Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1₩ M 2□F 87 547-18-7773 Yrs Director 16,1917 California Usual Residence of Decedent 2 should be filed within 72 hours after deeth with the Maryland is and Mental Hygiene.
Is marked other then "netural", or Iteme 23s or 28e-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or iteme 23a or 28e-f show traumatic event, the Madical Examinar must be notified at Md. Baltimore 1 ☐ Yes 2 No Director Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6313 Deer Park Rd. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1XX es 2 No 1943— If Yes, Give Year or Dates: 1972 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 1972 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) + 6 4 + Navy Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 shouid be f nent of Health and Mental I int: If item 27 is marked of Edward W. Foulkes Catherine Opie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Griffin - Daughter 6313 Deer Park Rd., Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1
Depertment of F
Important: If ite
eny injury or ot 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. Oct. 17, 2005 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel, P.A. 23a. Part1. En if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Cause (5):201 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fibrillation Ventricular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive
Due to (or as a consequence of) Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physicien and should be deteched for use as the burial-transit The law requires that the death certificate be executed Atherosclerone Cardiovascular Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastanc 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? certificete 2010 1 Yes or Attending Physician: After this certifice funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/12/05 0061755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NAGANNA HEMALATHA 706A PODLE RD WESTMINSTER, MD 21157 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 4 2005 Registrar

DHMH 17 Rev 1/2001

Carmen Gargo

	05-068	374		e Type or Prin						
	RPD		1 - State Amend Item Registrar Amend Item	State of Ma 1 per mne G 1 4c per me	aryland / Dep 848 10-14- 6848 Ce	artment of -05 tas rtificate of	Health and M Death ₁₀₋₂₄	ental Hygiei -05 ta s s	ne2005	33302
	Physici	an	Decedent's Name (First, Middle, I	last)	0			2. Date of Death	Day Year	3. Time of Death
	/Medio	al	Carmen 1	Vichael	Grago)		October '	9. 2005	0610 A M
	Examir	er	4a. Facility Name (If not institution, g)		or Location of Death	D .	Prince G	eorge's Co.
	Funeral		Malcolm Grow Hos 5. Social Security Number 6		e (In yrs. last birthday,	If Under 1 Year		8. Date of Birth	9. Bin	holace (State or Foreign
	 Director 		212-82-9638 Usual Residence of Decedent	1 MM 2□F	Yrs.	Months Days		Month, Day, Ye December 1	ar) Co	UYORK
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow he Madical Exertifier reset be notified at	_	10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 7 fe marked other than "naturel", or itema 23a or 28a-f ehov fraumatic event, the Madical Examinar mant be notified at	Director		les	Ma	IdorF				1 ☐ Yes 28 No
	with the		10e. Street and Number	00 . /		10f. Zip Code		10g.	Citizen of What Co	untry?
	Jeath True	Funeral	11. Marital Status	12. Was Decedent E	Street Ever in U.S. 13	Was Decedent of	Hispanic Origin? (Spe	offy Ves or No.	14. Race - Ame	nean Indian
9	or iter	Fun	1 ☐ Never Married 2 (Married	Armed Forces? 1 ☐ Yes 2 (\$\forall Y\)		If Yes, specify Cul	ban, Mexican, Puerto F	Rican, etc.)	Black, Whit	
93	ref.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No	Specity:		Specify:	hite.
21215-0036	"natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usual Occu	durina most of working	16b	Kind of Business	Industry
2	withir ene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire	9d)			
CA	Hygin of the		17. Father's Name (First, Middle, La	st)	2010	4002	18. Mother's Name	(First, Middle, Maio	en Sumame)	a compaix
<u> a</u>	should be filed with nd Mental Hygiene marked other the matic event, Ins.	To Be	Robert Fu	aene G	Rago		Tex-1	Mari	5<50	wein
Maryland	2 should and Men fe marke aumatic	-	19a. Informant's Name/Relationship	(Type, Print)	b. Maili	ing Address (Stree	t and Number or Rura	Route Number, of	y or Town, State, 2	Zip Code)
	C = 0 F			O-broth			Re Dive	Parkville	maylo	nd 21234
Baltimore,	to to		20a. Method of Disposition) □Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	D)	ate 20c.	Location - City or	Town, State
ţ	Pa ant: ury		4 □ Donation 5 □ Other (Spe	cify)			1-At OCT.	14,2005 FO	est HI	1, Maryland
Bal	Depention Depending Import Insport		21. Signature of Funeral Service Lic	ensee	25	2. Name and Addr				arford Road
		-	23a. and Enter the disease, of co	mulications that chused	the death. Do not an	ter the mode of du	hapel of n	Nemozies	Baltimur	Approximate
	Dhuniaian		23a. Fam. Enter the disease, of co shock, or heart failure. List on Immediate Cause (Final)	4		respiratory arrest,		Interval Between Onset and Death
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1	Examiner				a consequence ory.					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	b. Due to (or as a	a consequence of):					
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09	be executed sician and burial-transit	at Ex	resulting in death) Last	Due to (or as a	a consequence of):					
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Ä	death a etter d for u	clar	23b. Was decedent pregnant in the past 12 months? t □ Yes 2 □ No	1 ☐Live birth : 4 ☐ Pregnant at t	2 Fetal death 3	□Ectopic pregnand □ Other (specify)	Ey .		23d. Date of deli Month	very Day Year
P.O.	the de by the tached	hys	9 Unknown	9□ Unknown						
S,	Attending Physicien: The law requires that the death certificate actosable. Crosath. by P	Part II. Other significant conditions	contributing to death bu	it not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did tobacc	use contribute to	the cause of death?	
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ec S	has by	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
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Division of Vital Records,	ysician: These is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death			
ō	ng Physter this	: To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28b. Time o	IL JUDON	4 Nursing Hom	e 5 Residence		
ion	nding Ph tth. r: After th e funeral	atlor	1 □ Natural 5 □ Pending 2 ✓ Accident investigati	(Month, Day	Year) Injury	Wo	rk? Yes 2 GNo P		,	LSTRUCK by
vis	r Attend er death rector: / by the fi	Certification:	3 Suicide 6 Could not determine	-	ry - At home, farm, str (Specify)	•		8f. Location (Street	and Number or Ru	
Ö	rs efter ai Dii			P<	200 mmy	•	1	City or Town, Sta	,	VILLE MO
	To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	t my knowledge deat	h occurred at the li	ime, date and place, a	- 4 4 - 1 - 11		
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	.0		30-Name and address a series	Ulhe Jon	IL VI	0.C.	M.E.	0c	tober 10	, 2005
	\ 0		30-Name and address of person wh	Completed cause of de		,	Rol+im	Moser-1	nd 21201	
100	Sta	te	31. Date filed (Month, Day, Year)	32. Projetra	r's Signature	osuki	, Baltimor	e, maryia	HU ZIZUL	
	Registr	ar	OCT 1 4	2005 Seede	w B. A.	STATE OF THE PARTY				

Registrar

Amend item#195607, peop Printin Blackdodelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10, October 2005 6:33 A M Green Lavada /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F Lilbourn, MO Ĭ940 486-42-5037 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Director Indiana Lake Gary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 544 Georgia Street 46402 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: **Black** þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home $\frac{12}{1}$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Mae Lewis Wilmond Lee McBeth 19a. Informant's Name/Relationship (Type, Print)
Antionette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8615 Otter Creek Rd., Laurel, MD 20724 Antoinette Green (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/05 4 □ Donation 5 □ Other (Specify) Evergreen Mem. Park Hobart, IN 22. Name and Address of Facility
Guy & Allen Funeral Directors
2959 W. 11th St., Gart, IN 46404 21. Signature of Funeral Service Licensee Vellman Lennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a HOCK resulting in death) Last EDEMA. IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 thpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide

/Medical Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, peen : has certificate Physician: this After or Attending Director: 24 hours a Hospital

Funeral

Director

or 28a-f show ust be notified at

"natural", or

Hygiene.

and Mental Hygie

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked eny injury or other traumatic evone.

Physician

ould be filed within 72 hours after death with the Maryland Mental Hygiene.

signed by the attending physician and d be detached for use as the burial-trar Medical Certification: To Be Completed by Physician/Medical should page 2 completely filled in by the funeral director, 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D55403. 10/0/05

State Registrar 31. Date filed (Month, Day, Year)

DCT 1 4 2005

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH K. KITETAN, M.D., 7610 CARROLLAVE #260, TAKOMA PARK MD 20912

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** EDNA Lou 9 LEENE OCTOBER 12 17=05 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER LIKE A PEAKE MEDICAL CENTER BELAIN HANFOND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F Director 215-16-2915 Dec. 11, 1920 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes XXNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23e 508 South Fountain Green Road 21015 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: À 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be liled within 7; Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "ne any injury or other treumatic event, If a Medic once. Elementary/Secondary (0-12) College (1-4or 5+) HomeMaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mally Clyde Walter Bedsaul Coomes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roscoe L. Greene / Husband 508 South Fountain Green Rd., Bel Air, MD 21015 20a. Method of Disposition
1 Description 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2005 Air Mem.Gardens Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Maryland 21009 Ulmas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALUSE LUNDNARY ANTERY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause First Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS TYPE IL

Baltimore, Maryland 2121

ð pe Completed page 2 should certificate Be Certification: To this After death. Director filled in by Medical

or Attending Physicien: To the Hoepital within 24 hours a To the Funerel Completely filled

Mara

P.O. Vita of Division

State Registrar DHMH 17 Rev 1/2001

10

25. Was case referred to medical 27. Manner of Death 1 2 atural

1 XYes 2 No

2 Accident

3 ☐ Suicide

4 🗌 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖧 nknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yes 2 ☑ No

1□ No

1□ Yes

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ P/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License number

921809 M. O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMENIUM MID 21093

COLONARY ARTERY STENT

SIPLASHU Registrar's Signature M.O. Date filed (Month, Day, Year)

OCT 1 4 2005

5 Pending investigation

6 Could not be

determined

ORIGINAL

29d. Date signed (Month, Day, Year)

640grh12 2005

State of Mary

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rland / Department of Health and N	Mental Hygiene nn5	33305
Certificate of Death	Reg. No.	33303
	2 Date of Death	2 Time of Dooth

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

4.	U	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Davi Vara	3. Time of Death
Physic		Donald Carl Gu	yer			October	09 Year 2005	2:00 P M
/Medi Exami		4a. Facility Name (If not institution, give s		4b. City, Town, or	r Location of Death	OCCOBCL	4c. County of Death	2.00 F
LAdiiii				الم ما ما الما الما الما الما الما الما			II	
Funeral		702 Frans Drive 5. Social Security Number 6. Sex	7. Age (In yrs. last	Abingdo	If Under 24 Hrs.	8. Date of Birth	Harford 9. Birthp	lace (State or Foreign
Director		182-32-2459	M 2□F 64	Yrs. Months Days	Hours Min.	(Month, Day, You 18,	1940 Penn	sylvania
		Usual Residence of Decedent	0-1		<u> </u>	107. 10,	1740 1 1111	syrvania
anyland ehow		10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
Mar Mar	to	Maryland Harford	Abir	ngdon				1 ☐ Yes 2 XNo
1 the	Director	10e. Street and Number	110111	10f. Zip Code		10g	. Citizen of What Cour	itry?
3a o	D	702 Frans Drive		2.	1009		USA	
ns 2	Funerai		2. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	an Indian,
or he	F.	1 Never Married 2 Married	Armed Forces? 1XXYes 2 □ No		an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Vietnan	1 ☐ Yes 2X No	Specify:		Specify: W	hite
72 hc	ted	15. Decedent's Educ (Specify only highest grade		Sa. Decedent's Usual Occup	ation	16	b. Kind of Business/Inc	dustry
Mag	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	d)	rg .		
gien gien	Completed	12		Security Police	ce	U	.S. Govern	ment
al Hy al Hy Vent	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
uld b Ments rrked rrked	10	Carl William Gu	ver		June Est	her Swa	bb	
sho and h	i	19a. Informant's Name/Relationship (Typ		9b. Mailing Address (Street	and Number or Rura	il Route Number, C	City or Town, State, Zip	Code)
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other then "natural", or Items 23a or 28a-1 ehow ther traumatic event, the Medical Examplear qual be notified at		Sherry E. Guyer /	Wife	702 Frans Dr	ive, Abin	idon, Mar	vland 2100	9
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehov ery figury or other traumatic event, the Medical Engineer must be notified at once.	1 3	20a. Method of Disposition	0.000	of Disposition (Name of itery, crematory or other place			c. Location - City or To	
Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	,	1	12 05	lor some titoes	-11
artm orta		21. Signature / Funeral Service Lice	e/ / IIII	top Service (22 Name and Addre	ss of Facility	12-05 1	CWSCIL, Par	Arsuc
Depar Depar Impor eny ir	Ш	Much	mach				.77	7 01000
# b.		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that coused the death. D	o not enter the mode of dying	SOUTY RO	ad, Abing or respiratory arrest	don, Maryl	Approximate
*		shock, or heart failure. List only on Immediate Cause (Final	e caese on each line.	Λ - (*			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Positiono	1 Asply	wa			
Examiner			Due to (or as a consequent	ce of):				
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ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		,		23d. Date of delive Month	ery Day Year
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elaw hasb	ple	bease				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
The The page	Completed					performe	d? death?	2□ No
sician: Th certificete rector, pag	Be	25. Was case referred to medical			26. Place of Death			
ysic lis ce direc	2	examiner? 1.XXes 2 □ No Ho	ospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Oth	er: 4 🗌 Nursing Ho	ne 5 Residenc	ce 6 XXX ther (Specif	(y)
g Ph ter thi		27. Manner of Death		D. Time of 28c. Injury Work	y at	28d. Describe how	injury occurred	
or Attending Physicien: The law requires that the lifer death. Director: After this certificate has been signed by the line by the tuneral director, page 2 should be detached in by the tuneral director, page 2.	Certification:	1 □ Natural 5 □ Pending 2 ◯ Accident investigation	1019/05		Yes 2 No	subjec	ct stuck i	in window
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s afte	Ser	· _ romado	building, etc. (Specify)	lince	1	A louged a	State) 702 FV	tuz DV.
spit hour mera y fille		29a. Certifier 1 Cartifying Physi	cian: To the best of my knowled	dge, death occurred at the tin	ne, date and place,	and due to the cau:	se(s) and manner as s	tated.
ne Ho ne Fi	edicai	one) (Check only ZXMedical Examin	er: On the basis of examination and manner stated.	and/or investigation, in my o	pinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ž	29b. Signature and title of certifier		29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
(1 (a side it	allown in		C.M.E.		October 10	2005
			- 100	0.	O . II . II .		OCTOBET TO	J, 2001
V		30. Name and address of person who cor	npleted cause of death (Item 23:	a) (Type, Print)				
N		30. Name and address of person who cor	npleted cause of death (Item 23:		Street F	laltimoro	, Maryland	21.201

Registrar

OCT 1 4 2005

Edward Gnip Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06908 State of Maryland / Department of Health and Mental Hygiene 0 5 RPD 1- State Registre Amend Item #8 Per FH C848 10/97/055 atm of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 10, 2005 **Physician** EOWARD GNIP 1945 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CITY BALTIMORE Baltimore Maryland General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X**M 2□ F 80 192-12-8573 Mar 06,1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f ehow traumatic event, the Medical Examiner rough be notified at 1 Yes 2 No BALTIMORE ND Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. EUTAW STREET 21201 or items 23a 816 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 1 by Yes 2 □ No 1943 If Yes, Give Year or Dates: 1946 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 Divorced 1946 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic aven." SHIPPING Elementary/Secondary (0-12) College (1-4or 5+) LONG SHOREMAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANNA HLATKY GNIP JOHN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 15 19a. Informant's Name/Relationship (Type, Print) HELEN GNIP ZOILLA 309 COMANCHE DILLE BELLE VERNON PA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MARYLAND BAYVIEW CREMYORY OCT. 15. 2005 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MARZULLO FUNERAL CHAPEL 21. Signature of uneral prvice picens 6009 HARFORD BOAD BALTIMORE, MD ZIZIY LFP Part . Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm—1 at Cause (Final disease or condition resulting in death) Atheroscherotic card iour scular disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and tor use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 X Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 22 ER/Outpatient 3 □ DOA Certification: To 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The desired in the desired of the desired at the time, date and place, and due to the date(s) and marrier as stated.

2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7 ast October 11, 2005 000 No O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001

OCT 1 4 2005

lasha

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 = For Stata Registrar	State of M	laryland / De	epartment of F Certificate of	lealth and M Death			005	33307
			Decedent's Name (First, Middle,	Last)		oranoato or	Journ	2. Date of Dea			3. Time of Death
ı	Physici		Aurelius Hens	son				Month 10	Day () 9	Year 05	5:35 P M
	/Medic Examin		4a. Facility Name (If not institution,)	4b. City, Town, o	r Location of Death			unty of Death	1
			Washington Adv	entist Hosp	ital	Takoma	Park		Mo	ontgome	ery
	Funeral			6. Sex 7. A	ge (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10 07	Year)	Cou	pplace (State or Foreign untry)
	Director		577-44-6860 Usual Residence of Decedent		70 Yr	o		10 07	33	VI	rginia
	ylanc how		10a. State 10b. County		10c. City, Town of						10d. Inside City Limits
	Ba-f s	ctor	MD Princ	e Georges	Upper	MArlboro					TX∏Yes 2 No
	with the	Director	10e. Street and Number	g		10f. Zip Code		1	0g. Citizer	of What Cou	untry?
	eath v	Funerai	12003 Wimblet	on Street 12. Was Decedent	Everin IIS	20774	Isnanic Origin? (Spe	acify Yes or No-	14	Race - Amer	ncan Indian
36	be filed within 72 hours after death with the Maryland lat Hygiene. Id ether than "natural", or Items 23a or 28a-f show event, the Medical Exarifrer must be rodified at	by Fun	1 Never Married 2 X Marrie	Armed Forces od 1 Tyes 2 X If Yes, Give	? INo	 Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 ☒ No 	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc.
5-0036	72 hour natural	eted b	3 Widowed 4 Divorced 15. Decedent' (Specify only highes)		16a. D	ecedent's Usual Occup	pation	ina	16b. Kind	of Business/I	ndustry
2	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Give kind of work done ife. DO NOT use retired		,,,9		_	
d 21	filed Hygi ther int,		17. Father's Name (First, Middle, L	4 yrs.	Ir	vestigator	18. Mother's Name	e (First, Middle,			rnment
Maryland	ould be Mental arkad o	To Be	Otis W. Henson	·			_	e Hackn		,	
ary	2 should be and Mental is marked or reumatic ever	_	19a. Informant's Name/Relationsh			Mailing Address (Street	and Number or Rura	al Route Numbe	r, City or To	own, State, Z	(ip Code)
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alti	permit. Page Department Important: Il any injury of any injury of ance.		21. Signature of Funeral Service L	**	-	22. Name and Addre	ss of Facility MAr	shall's	Fune	ral Ho	ome
<u> </u>	89 5 8 8		PY	naish	all	4217 9th.				D.C. 2	20011
П			23a. Part1 Enter the disease, or o shock of heart failure. List of	iniv one cause on each i	line.						Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	convey	CALATO, COLATO,	D. SMI			-	
	Examiner			Due to (or as	s a conseque, ce of	COLATO	MI PATA	4.			
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687	fficate g phys	edicai		d							
ŏ	eath certifi attending for use as	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal death	3 Ectopic pregnance	v		230	d. Date of deli	•
O. B	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death	5 Other (specify)				Month	Day Year
۵.	res that th igned by be detac		Part II. Other significant condition	ns contributing to death	but not resulting in t	he underlying cause giv	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds,	quires n sign ald be	d by						1 🗆 Y	es 2 🗆 l	No 3□Pr	obably 4 🛣 Unknown
Record	aw requir is been si 2 should (ompieted						24a. Was a		24b. Were au	topsy findings available
	The ate h page	Com						autop perfor 1 ☐ Yes		death?	completion of cause of 2 \(\text{\subset}\) No
/ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	ne)		
of 0	Phys this al di	O I	1 Yes 2 No	Hospital:		atient 3 DOA	ner: 4 ☐ Nursing Ho				cify)
on	ling After	tion	1 Natural 5 Pending 2 Accident investig		ury 28b. Tin ay Yea <i>r)</i> Inju	ıry Woi	rk? Yes 2 □ No	28d. Describe h	OW INJURY O	occurred	
Division of	il or Attending after death. Director: After d in by the fune	ertification;	3 Suicide 6 Could n	ot be 28e. Place of In		n, street, factory, office				Vu <i>mber or R</i> u	ıral Route Number,
á	5 # # €	Cert	4 Homicide	building, e	tc. (Specify)			City or Tow	n, State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	ledicai	29a. Certifying (Check only one)	Physician: To the best	of examination and/	death occurred at the til or investigation, in my o	me, date and place, opinion, death occur	and due to the dred at the time, d	ause(s) an	nd manner as ace, and due	stated. to the cause(s)
	To the I	Mec	29b. Signature and title of certifier	and manner s	14104.	29c. Licens	se number	:	29d. Date s	signed (Monti	h, Day, Year)
}	F > F 0	1	Museus	resout		NO	57614	1 p	101	9/03	7,
	6		30. Name and address of person v	nho completed cause of	death (Item 23a) (T	ype, Print)			1	2222	
	0		DR. Dan m	. Colum	1AN 760	00 Carroll	Ave. Tako	ma Park	, MD.	20912	
	Sta Registr		31. Date filed Worth Day, Year)	005 Hegist	trar's Signature	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () 5 1- State Regist Amend Item 17 per fh G848 10-18-05 icate of Death tas 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CA2L HANSEN, Jr October 12 14-33 M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death UPPERCHESAPEALE MODILAL CENER HALFOND 3 EL Ann Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex -1- M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Yrs 216-54-6103 1949 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Every Ir et roust be notified at 1 Yes 2 No Directo Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2318 Turner Lane "natural", or items 23a 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1XYes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Auto Technician Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Erma Lillian Schunch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any injury or other trau Susan Hansen / Wife 2318 Turner Lane, Bel Air, Maryland 21015 20a. Method of Disposition

↑□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 10-17-05 Baltimore, Maryland ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 nature of Funeval Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HADOUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABFRED MERLYTON 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 Proutpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OUT 12, 2005 021809 MU DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 PNA SHU

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2336 42. Registrar's Signature

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CPM 05-06796 Amend/Unpend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend/Unpend Tren#1,23a,27,28a-f, perME, G848,10/15/05 Tren#1 State of Maryland / Department of Health and Mental Hygiene Bridgette Hudgins 1 - For State Registrar 33309 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Bridget G. Hudgins Year **Physician** 05, October 0 2005 19:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7816 Eastern Boulevard Baltimore <u>Eastpoint</u> If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) June 7,1953 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🕅 F Yrs. 52 Director 220-64-5576 Maryland Usual Residence of Decedent the Maryland 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow rthan "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 XYes 2 No Baltimore City Maryland N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2025 East Lombard Street 21231 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) f Heelth and Mentel Hygiene. Item 27 is marked other than other treumatic event, the M 10 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) Ukn. 18. Mother's Name (First, Middle, Maiden Sumame) Be Joanna Barlow ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 415 Brooks Ct. Glen Burnie, MD 21060 Dianna Marketti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages 'Department of Fimportant: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/11/2005 Towson, Maryland □Donation 5 □ Other (Specify) ature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Hall Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Heroin Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons »quence of) Examine The lew requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burlal-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 □,Yes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of a ?

1 ★ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1X Yes 2 □ No To the Hospital or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA examiner? 1X Yes 2 □ No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textit{NOther (Specify) SCENE} ٩ this Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 7:09 P M 1 ☐ Yes 2 No death. 2 Accident 10/5/2005 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 7816 Eastern Blvd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 흅 Found at home within 24 hours a To the Funeral C completely filled Eastpoint, MD Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Registrar 0CT 1 4 2005

31. Date filed (Month, Day, Year)

30. Name and address of person who complet

11 Aronic

111 Penn Street, Baltimore, Maryland 21201

of death (Item 23a) (Type, Print)

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O.C.M.E.

October 06, 2005

State of Maryland / Department of Health and Mental Hygier ? 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 12:01 AN WILLIAM LINWOOD IRELAND 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth Dec. 26,1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours XXM 2DE Days Min 214~16~6359 85 Yrs Director Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Department of Health and Mental Hygiene. Important; if Items 23a or 28a-1 show important; if Item 271s marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, if a Macical Examinar must be notified at once. Maryland Baltimore Baltimore County 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 8931 Yvonne Avenue USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White WW 11 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 yrs. Supervisor Bethlehem Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Rebecca Hall William Leroy Ireland ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1042 Barrymore Drive Belair, Md. 21014 Karen Harrison (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 Gardens of Faith Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-14-2005 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. 21. Signature of Funeral Service Licensee Home Baltimroe, Md. 21236 3 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) lile /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 SUnknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 ₽□ No 1 TYes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending after death.
Director: Ald in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 | Homicide within 24 hours a

To the Funeral completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03225 October 12, 200-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 DR. DAVID DUNN, 615 MACPHAIL ROAD, BEL AIR, MD 21014 31. Date filed (M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0.051- State Registra Amend Item #8 Per FH C848 10 197165 atem of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician October 13 2005 5:50a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 232-30-7897 Director Mar 09,1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** ir than "naturel", or iteme 23a or 28a-f ehov the Medical Exeminar must be notified at Himore 1 Mes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 JUVYUN 6 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No IMes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married 1□Yes 2X No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns eny injury or other traumatic event, the Musils once. Elementary (Secondary (0-12) College (1-4or 5+) Wor 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) UNK 2 a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Rout) Number, City or Town, State, Zip Code) Jak. Baltimore, MD 2120+ 5/14 (Sowynn 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) Donation arrison 21. Signature of Fune a Service Cit MD town. 23a. Part1. Enter(the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** /Medical Examiner appen Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of): Box 68760, the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 ☐ Live birth 2 ☐ Felal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) sate has been signed by the page 2 should be detached o نه ins contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, 1 Xes 2 □ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 PNatural To the Hospine, within 24 hours after death.

To the Funeral Director: After the Funeral Director of the fur 5 Pendina investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29b. Signature and title of certifier D44467

DHMH 17 Rev 1/2001

State

Registrar

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nth, Day, Year)

OCT 1 4 2005

poste

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UTTONE

Registrar's Signature

Physician JERRY LEROY JUNG 4s. Facility Name (if not allowed as present and number) 4s. Fac	3312
SERRY JUNG STATE LERRY JUNG STATE Control of Death Control	3. Time of Death
Social Security Numbers Social Security	0058 ^M
Second Security Number Security Number Se	
Use of the part	e (State or Foreign
MD. N/A BALTIMORE 102. City, Town or Location MD. N/A BALTIMORE 103. State 100. County MD. N/A BALTIMORE 104. City Code 105. City Code 105. City Code 106. City Town or Location 107. Sp. Code 107. Sp. Code 108. City Code 109. City Code 109. City Code 109. City Code 109. City Code 109. City Code 100. State and Number 100. S. BELNORD AVENUE 110. State and Number 100. Sp. Bellor Code 100. City	YLAND
Section Part	Inside City Limits
Section Part	1 XYes 2 □ No
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20a. Method of Disposition Burial 2 Comments Date 20c. Location - City or Town, St	
20a. Mathod of Disposition Burial 2 Cremation 3 Removal from State	
Physician Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interest the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interest the disease or conditions are diseased or conditions. If any, leading to immediate cause. Enter Underlying to death or put to (or as a consequence of): Due to (or as a c	
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Physician Medical Examiner Physician Medical Examiner Physician Medic	21231
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	proximate erval Between
Due to (or as a consequence of): Comparison Comparis	nset and Death
Composition of the part of the	
that initiated events resulting in death) Last C	
The standard of the standard o	
FFEMALE. 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown 23d. Date of delivery Month Day 23d. Date of d	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the conditions of the conditions of the cause	UGHI-SE
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the conditions of the conditions of the cause	
Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 236. Did toolacco use contribute to the cause of the	y Year
25. Was case referred to medical examiner? 10X7es 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Wother (Specify) Sc	ause of death?
25. Was case referred to medical examiner? 10X7es 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Wother (Specify) Sc	y 4 ∐Unknown
25. Was case referred to medical examiner? 1 \(\)\text{Sec} = \text{D} \\ \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{6} \text{Nursing Home} = \text{5} \text{Residence} = \text{7} \text{Residence} = \text{8} \text{Residence} = \text{8} \qq \q\	etion of cause of
1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Wire 4 Nursing Home 5 Residence 6 Other (Specify) Sc	
	cene
27. Manner of Death 27. Manner of Death 1 Natural 5 Pending investigation investigation 2 Accident investigation 3 Suicide 3 Suicide 4 Natural 5 Pending investigation 5 Pending 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Suicide 5 Pending 28c. Injury at Work? 28d. Describe how injury occurred 5 Suicide 5 Pending 5 Pendi	ect shot
To be the control of	oute Number,
Start Start	
2 Accident 3 Suicide 4 Homicide Could not be determined Suicide 4 Homicide Su	d. cause(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, You	, Year)
/ family fouthall, MI) OCME October, 12, 20	2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panela E. Southail, mi) 111 Penn Street Baltimore, Maryland	d 21201
Registrar 31. Date filed (Month, Day, Year) Registrar 0CT 1 4 2005	

			1 - For State Registrar	State of Maryland	d / Depa	artment of H	lealth and M Death	fental Hygiei		33313
	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Helen	Elizabeth	Kild		Location of Death		12, Year 20 4c. County of Dea	
	Examir	ner	4a. Facility Name (If not institution, give s Oak Crest	treet and number)			ville		Balti	
{	Funeral		5. Social Security Number 6. Sex	9 , , , , , , , , , , , , , , , , , , ,	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)
6	Director		214-20-8466	M 20XF 92	Yrs.	Months Days	Hours Min.	Aug. 13,1	.913 Ma	ryland
0	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
7	Marylar -f ehow	to	Maryland Baltimore	P;	arkvil	le				1 ☐ Yes 2X No
-	with the Maryland a or 28e-f ehow be notified at	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
1	23a c	Funeral Director	8800 Walther Blvd.	, Unit 4107		21234			U.S.	
7	er des	nue		12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
7 8	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1⊡Yes 2√√No	Specify:		Specify: Wh	ite
٦ ا	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	ina 16b	, Kind of Business	
7 5	Athin No.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,,,,,		
C 5	Hygien Ther th		17. Father's Name (First, Middle, Last)		Hom	nemaker	18 Mother's Nam	e (First, Middle, Maid	Own Home	
Chts (2th 2	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiens. Important: If Item 27 is marked other then "natural", or Items 23a or eny injury or other traumatic event, the Medical Examinar must be ance.	To Be	Thomas Near	V			Cather			
- A 2	shoul mark	-	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street a		al Route Number, Ci		Zip Code) 21152
	end 2 salth an 27 in		Joan C. EdgarD				eek Way,	Unit 308	Sparks,	Maryland
	i of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	metery, crei	sition (Name of matory or other plac	θ)		. Location - City o	
Saltimore	t. Pag rtmen rtent:		Donation 5 ☐ Other (Specify)	Mays				5-2005 Tim		Maryland
a d	permi Depar Impor eny Ir		21. Signator of Fundal Service License	0		.050 York		ck Towson owson, Mar		Home, Inc. 21204
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. e cause on each line.	. Do not ent			or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cancer à	6	100 B1	110/7	re		Onset and Death
	/Medical Examiner			Due to (or as a conseque	ence of):					
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
	nd Iransit	Examiner	that initiated events							
8760.	cate be executed physiclen and the burial-transit	ai Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
687	ficate p physics ts the	edicai	_ d			w				
Box	death certific e attending p ed for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnan		7E			23d. Date of de	elivery
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 MNo	4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
0	het the d by Jetac		9 ☐ Unknowr (` Part II. Other significant conditions con		lting in the	ndarhing agus au	na in Boot I	22a Did tobacc	no uso contributo	to the cause of death?
Division of Vital Becords.	requires thet the	d by	raith. Other significant conductions (or)	mooning to death but not resul	ning in the u	ndenying cause give	in in Fanti.	1 ☐ Yes	/	Probably 4 Unknown
Ö	law requir es been s 2 should	olete						24a. Was an	24b. Were a	utopsy findings available
B	The lav	Completed						autopsy performed	? death?	completion of cause of
ita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?					h (Check only one)		
	Physician: this certific ral director,	ပ္	1 ☐ Yes 2 ☐ H	ospital:				me 5 Hesidence		ecify)
	ding h. After funer	tion	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat (? Yes 2 □ No	28d. Describe how is	njury occurred	
İSİ	Atten r deat ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne, farm, str			28f. Location (Street	t and Number or F	Rura I Route Number,
وَ	rs afte	Certification;	4 Homicide determined	building, etc. (Specify)				City or Town, Si	tate)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or in	occurred at the time vestigation, in my of	e, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and du	e to the cause(s)
	To th To th	M	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mon	nth, Day, Year)
	<i>C</i> :		1 put	cm		DI	3115	Oc	hdu 13t	4 2005
	8			inpleted cause of death (Item :	23a) (Type,	Print) W Bl-J	Park	ville Mi	7 2123	rij
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 4 200	32 Registrar's Signatu	ire do	ule				
					-					

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cel</i>	artment of H	lealth and Mo Death		en2005	33314
	Physic	ian	1. Decedent's Name (First, Middle, Las.	1				Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give	Lagne	se	4h City Town or	Location of Death	October	4c. County of Deatl	
	Exami	ner		GSBURY D	DRIVE	40. City, Town, or	PPA		HARE	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9 Birth	polace (State or Foreign
	Director		215-16-2131 15 Usual Residence of Decedent	XM 2□F 82	Yrs.	Lancing Suyo	-	July 15,	1923 Mar	yland
	yland yland		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	e-fat	ctor	Maryland Harfor	d		Joppa				1 ☐ Yes 2 🕱 No
	vith th	Directo	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	eath v	Funerai	2409 Kingsbury D.	12. Was Decedent Ever in	119 131		085	cify You or No	U.S.A.	ncan Indian
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23a or 28e-f show event, the Medical Era hit et in tal be notified at	by	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW		f Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto F Specify:	Rican, etc.)	Black, White	
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	lent's Usual Occupa	furing most of workin	16	b. Kind of Business/I	ndustry
121	within ene. then	dmo	Elementary/Secondary (0-12) 10th Grade	College (1-4or 5+)		00 NOT use retired thographe	•	Co	ontinental	Can Ca
d 2		Be Co	17. Father's Name (First, Middle, Last)			Inographe	18. Mother's Name			can co.
/lan	2 should be and Mental le marked ceumatic eve	To B	Frank Lagnese				Angela	Pasquo	rlone	
Maryland 21215-0036	5 등 전 E		19a. Informant's Name/Relationship (T) Mrs. Barbara Lagn				and Number or Aural			ip Code)
Baltimore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, cren	sition (Name of natory or other place		ate 20	c. Location - City or 1	Fown, State
ţ	nit. Pages artment of l ortent: If It injury or o		'4 □Donation 5 □Other (Specify)	Ga			Cem. 10/14			
Bal	permit. Pages Department of I Importent: If Its any injury or o		21. Signatur of Inval Service Licens				is of Facility Schu ir Rd., Bo			
b			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on each line.				respiratory arrest		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	TAGE	. DEM	アントンリン			5 Years
	Examiner				querice or):					
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
_	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	e be e sician e buris	dicai E		1	,					
89	tificati ng phy as the	0								
.O. Box	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
<u>G</u>	res that thigned by	Ph)	Part II. Other significant conditions cor	stributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	quires n sign	ed by						1 ☐ Yes	2 ∑ No 3 ☐ Pro	bably 4 Unknown
Vital Records,	The law requirate has been sipage 2 should l	ompieted						24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
		Be C	25. Was case referred to medical				26. Place of Death		No 1 ☐ Yes	2 No
	8 0 7	2	TE TOS ZZ NO		ER/Outpatient	3□ DOA Othe	r: 4 Nursing Hom	e 5 X esidenc	e 6 Other (Spec	ify)
o U	ding P h. After t funera	ii o	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	?	3d. Describe how	injury occurred	
Division of	or Attending after death. Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre		es 2 □No	Bf. Location (Stree	it and Number or Rui	ral Route Number.
2	al or Att s after d il Direct ad in by t	Certification;	4 Homicide determined	building, etc. (Speci	fy)	or, radiory, ornoc		City or Town, S		
	id of	edlcai	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knoter: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, an inion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of pertifier	Dung	101	29c. License	number 2 41 4	7 29d.	Date signed (Month	Day, Year)
i	11	-	30. Name and address obperson who/co	mpleted cause of death (Iter	п 23а) (Туре, Р	Print)	0-111			
0	, 7			an mo	101	1. Gre	ene St.	Balt	timore	m) 21201
	Stat Registra	_	31. Date filed (Month, Bay, Year) OCT 1 4 2	32. Redistrar's Signa	ature A	barle			`	

		State of Maryland / Department of Health For State Registrer Certificate of Deatl			giene 0	05	33315
Physiciar	n	Decedent's Name (First, Middle, Last)		Date of Dea		Year	3. Time of Death
/Medica	al -	Mary Ridgely Poe Lang 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location	n of Death	2ct	4c. Count	200 S	6.05AM
Examine	er	Mariner Health of Bel Air Bel A	/ Y		14	arto	rd
Funeral		Months Days Hours	er 24 Hrs. 8. E	Date of Birt Month, Da	h y, Year)		nplace (State or Foreign untry)
Director		Usual Residence of Decedent	INO	v. 24	, 1913	Ma	ryland
death with the Maryland rms 23a or 28e-f show	ō,	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 📆 No
ith with the M 23a or 28e-f	Directo	Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code			10g. Citizen of	What Cou	untry?
th with	a D	303 Kennard Ave. 21040			Ţ	JSA	
er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify can, Puerto Rica	Yes or No- n, etc.)	14. Ra Bla	ce - Amer ack, White	rican Indian, e, etc.
Urs aft	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No 3 ☒ Widowed 4 ☐ Divorced Year or Dates: 1 ☐ Yes 2 ☒ No Specify	fy:		Speci	fy: VJ	hite
15-0	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mo	ost of working		16b. Kind of 8	Business/I	industry
212 d withir plane.	d l	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker			Own Ho	me	
nd ; be filed tal Hyg d othe	Rec	17. Father's Name (First, Middle, Last)	ther's Name (Fir		Maiden Suma		
Maryland 21215-0036 at 2 should be filed within 72 hours aff lith and Mental Hygjene. 27 Is marked other then "natural", or creaumatic event, the Medical Exert To Be Completed by E	0	William Charles Poe Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num.			idgely	Ctoto 7	in Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural," or items 23a or 28e-1 should in your or other traumatic event, the Medical Expirity must be to differ a spice.		Mary L. Thompson / Daughter 301 Kennard Ave.,					
Baltimore, semil. Pages 1 ar Department of Hea mportent: If tem iny injury or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		20c. Location	•	
Iltim iit. Pag artment ortent:		4 Donation 5 Other (Specify) Bel Air Memorial Gran		-		, Ma	ryland
Ball permit Depart Import any r		21. So halure of Funeral Service Licensee 22. Name and Address of Face MocComas Funeral 1317 Cokesbury	al Home y Road,	, P.A Abin	adon, M	arvl	and 21009
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.					Approximate Interval Between
/Medical		Immediate Cause (Final disease or condition resulting in death)					Onset and Death
Examiner		Due to (b) as a consequence of):					~ 6
	Je L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
60, be executed ician and burial-transit	Xam	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
		d					
X 68 X 68 Certifica Certifica Lise as th	меа	IF FEMALE:					
P.O. Box 6876 nat the death certificate be d by the attending physici letached for use as the buphysician/Medical	Clary	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No				ate of deli onth	very Day Year
IS, P.O. I	2	9 Unknown 9 Unknown					
	ה <u>ל</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.	23e. Did to	_/		the cause of death?
ecord law require as been si	בובו			24a. Was			topsy findings available
Mar al Record The law require cate has been s page 2 should	5			autop		prior to c death? 1 \(\text{Yes}	completion of cause of
of Vital F Of vital F Physician: Th this certificate ral director, pag	D 1	examiner/	ice of Death (Ch				
To To	-		Nursing Home		tence 6 □Ot		cify)
Vision (Vision) of Attending In death. ector: After Eurer by the funer iffication:		27. Manner of Death 1		Describer	iow injury occu	1160	
Division of Division of tall or Attending Part death. The Division of tall or Attending Part death. The Director: After the diviner of the tuners. Certification:		3 Suicide 4 Homicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (5		ber or Ru	ral Route Number,
Divi		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place and s	due to the	20100/2) 2010		atatad
Div To the Hospital or within 24 hours after To the Funeral Dire completely filled in L		(Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	eath occurred at	the time,	date and place	, and due	to the cause(s)
To the company of the		29b. Signature and title of certifier D 5654	5		29d. Date sign	ed (Month	n, Day, Year)
V	;	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shi pi 1	Khosla				
State Registrar		OCT 1 4 2005					

DHMH 17 Rev 1/2001

Janice Mellerson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a, PI, G850, 12/1/05 11 05-6905 1- For Unpend Item 23a, pt. 11,27 per me 6849 1 1-1-05 tas Mental Hygiene 0 0 5 Certificate of Death Reg. No. AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005^{ear} **Physician** October 10, MELLERSON 6:05 P ALEATHEA ANICE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Mercy Hospital NIA 8. Date of Birth (Month, Day, Year) I-EB: 13, 1962 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🗷 F 212-84-5206 Yrs. MARV Director LAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, its Modical Examinational be nutified a once. 1 XYes 2 □ No Director MARYLAND 10e. Street and Number 10g. Chizen of What Country? RICKER Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2,5No þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $OW \kappa$ 12 HGRADE MEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WELBON ZYNTHIA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIHOKE MD. 21225

20c. Location - City or Town, State WELBON MELLERSON FATHER 4 DEACON HILL CT. 20b. Place of Disposition (Name of 20a. Method of Disposition Date / cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BUTUS CEMETERY 10-18-05 BALTIMORE MARKAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility 21. Signature . BROWN UR FUNERAL HOME BALTO, MD. 2121 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Healed Endocarditis complicating artificial heart valves disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transl Due to (or as a consequence of): P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy į in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chronic narcotism, end stage renal disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ₩ ≥ 2 □ No 24a. Was an Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 25€ER/Outpatient Other: 2 1 √Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending Injury 1 Natural 2 Accident within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 11, 2005 O.C.M.E. alsha

Registrar

State

31. Date filed (Month, Day, Year)
OCT 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ree where M. U 111 Penn Street, Baltimore, Maryland
32. Regultrar's Sphature

05-06945 Rudolph Martin, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

olph Mai	rti		I / Department of Health and M Certificate of Death	ental Hygier	ne2005 33317			
Physic /Med		1. Decedent's Name (First, Middle, Last) Rudolph Sterling Martin, Sr.	Certificate of Death	2. Date of Death Month October	No. 3. Time of Death 12, 2005 13:15 M			
Exami	iner	4a. Facility Name (If not institution, give street and number) University of Maryland-Shock Tra 5. Social Security Number 6. Sec. 7. Age (In yrs. Ia	st birthday) If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death 9. Birthplace (State or Foreign Country)			
Director wow			Yrs. Town or Location	March 3,	1970 Jamaica 10d. Inside City Limits			
with the Ma ta or 28a-f	Director		Reisterstown 10f. Zip Code	10g.	1 □ Yes 2 No Citizen of Whal Country? USA			
be filed within 72 hours after death with the Maryland ital Hygiene. Indi Hygiene. Indicate then "natural", or Iteme 23a or 28a-1 show event, the Modeal Examinat must be natilized at	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	21136 13. Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2⊠ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black			
within 72 ho ane. then "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired) Sales		Kind of Business/Industry Real Estate			
be filed ital Hygi od other	To Be Co	17. Father's Name (First, Middle, Last) Lloyd Martin	18. Mother's Name	(First, Middle, Maid				
s 1 and 2 should f Health and Mer Itsm 27 is marke other traumatic		19a. Inlommant's Name/Relationship (Type, Print) Mary K. Martin Wife	19b Mailing Address (Street and Number or Hura 53 Caraway Road, Reist	erstown,	MD 21136			
permit. Pages 1 an Department of Heal Important: If Itsm 2 eny injury or other once.		1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) A 1 1	Saints Cem Oct.	19, 2005	Reisterstown, MD			
Depar Impor eny in		21. Signature of Funeral Service Licensee Stephen M. Jensen	22. Name and Address of Facility Eline Funeral Home	Reiste	Reisterstown Road rstown, MD 21136			
Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that daused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque	Torso Injuries wit		Onset and Death			
icate be executed physiclen and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenls resulting in death) Last b. Due to (or as a consequence of the consequen						
The law requires that the death certificat sie has been signed by the ettending phypage 2 should be deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of deal 9 □ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year			
v requires that been signed b should be dete	<u>چ</u>	Part II. Other significant conditions contributing to death but not result	occo use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown					
	Completed			24a. Was an autopsy performed				
Physician: 1 this certifice el director, p	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ E	26. Place of Death R/Outpatient 3 DOA Cther: 4 Nursing Ho		e 6 ☐Other (Specify)			
tal or Attending I is efter death. el Director; After ed in by the funer	Certification;	27. Manner of Death 1. Natural 5 Pending investigation and Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 3 Suicide 4 Homicide 28b. Time of Injury 28c. Injury at Work? 3 Suicide 6 Could not be determined 28c. Injury at Work? 3 Suicide 6 Could not be determined 28d. Describe how injury occurred 1 Ville 6 Describe how injury occurred 1 Ville 6 Describe how injury occurred 28d. Des						
중수 필 등	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know one to the basis of examination and manner stated.	ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)			
To the within 2 To the complex	-	29b. Signature and title of certifier Signature and title of certifier Halour V	29c. License number OCME	(Date signed (Month, Day, Year) October 13, 2005			
16		30. Name and address of person who completed cause of death (Illem :		et Baltin	more, Maryland 21201			
St	ate	31. Date filed (Month, Day, Year) OCT 1 / 2005	Last D					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005

33318 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year William Massa October 4, 2005 8:25 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Friends Nursing Home Montgomery Sandy Spring If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Director 112-07-0650 July 6, 1913 Usual Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours aftar death with the Maryland Departmant of Health and Mantel Hyglena. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14206 Clayton Street 20853 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Porces:
1 X Yes 2 3 10 17 - 41
If Yes, Give
Year or Dates to 12 - 45 1 Never Married 2 Married 3altlmore, Maryland 21215-0020 1 ☐ Yes 2 No ğ Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Secretary 12 Carpenters Union 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bartholmew Massa Maria Gazia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (POA) Mary Reese 14206 Clayton St., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/05 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility Neptune Society 21. Signature of Funeral Service Licensee 531 E. Oakland Park Blvd., Oakland Park, FL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final , SEPSIS disease or condition resulting in death) two weeks **Examiner** Due to (or as a consequence of): SACRAL DECUBITES One wonst ettending physician and for use es the burial-trensil Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 To the Hospital or Attanding Physician: The law requires that the death certificete be within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be detached for use es the burn Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown DYSPHAGIA ģ Completed 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? certificete has b lirector, paga 2 si 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Certification: To 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edlcai 1XI Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Yeer) 29c. License number NUV OCTOBER 05, 2005 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 2901 RD1472108 OLNEY MARYLAND 2082) DENVIS HANNON MO

. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 4 2005

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygien	1	N	5	3	3
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			For State Registrar	State of M	aryland / De	epartment of Certificate	of Health of Death	and Me		ien ? () ()5	33319
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	th		3. Time of Death
	Physici		Harry Ronald Mc	Cowan				C	Month	7, 200	Year 5	4:20 AM M
	/Medio Examir		4a. Facility Name (If not institution, giv		r)	4b. City, Tov	wn, or Location		00000	4c. County		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	LAGITIII	ici	Montgomery Genera	1 Hospita	1	01ney				Mont	gomer	v
	Funeral		5. Social Security Number 6. S	Sex 7. A	age (In yrs. last birtho	ay) If Under 1 Y	ear If Unde	er 24 Hrs.	8. Date of Birth		9. Birthpla	ace (State or Foreign
	Director		190-30-4746	X M 2□F	66 Yrs	. Months D	ays Hours	Min.	May I,	1939	Penn	sylvania
	ט		Usual Residence of Decedent									
	ylen how		10a. State 10b. County		10c. City, Town o	r Location					10	d. Inside City Limits
	Ma-is	ţo	MD Montgon	nery	Silver	Spring						1 □ Yes 2 □ No
	or 28	lre	10e. Street and Number			10f. Zip Co	de		1	0g. Citizen of V	hat Count	ry?
	within 72 hours efter death with the Marylend ene. than "natural", or Items 23a or 28a-1 show ha Medigal Examinar maal be notified at	by Funeral Director	15005 Timberlake	Drive		109	05			USA		
	dea	ner	11. Marital Status	12. Was Deceden Armed Forces		13. Was Decedent	of Hispanic O	origin? (Spec	efy Yes or No-		- America k, White, e	
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □	No4/21/58	1 ☐ Yes 2 🔀				Specify		
21215-0036	ral.	D D	3 Widowed 4 Divorced	Year or Dates	: 4/02/60		(1.0 0,000)	,.		Specify	Wh	ite
5-0	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(6	ecedent's Usual O live kind of work of	lone durina ma	ost of working	9	16b. Kind of Bu	siness/Indu	ustry
21	ithin Jan	du	Elementary/Secondary (0-12)	College (1-4or	r 5+)	e. DO NOT use r	etired)					1 36
	ygien ygien ygien ygien	S	12		Con	puters	40.14.11			<u> </u>		d Martin
P	ba fil tal H d otl	Be	17. Father's Name (First, Middle, Last,	,						Maiden Sumam c	θ)	
yla	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", ' 'aumatic event, the Medical Era	은	Harry McGowan						lderhof			
Maryland	2 sh and ls m		19a. Informant's Name/Relationship (**		ailing Address (St 005 Timb				-		
	and lealth m 27 her t		Carol A. McGowan	- wile		sposition (Name of		DIIVE			-	
O.	Jes 1 If Ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	e cemetery,	crematory or other	r place)			20c. Location -	City or Tow	m, State
Ë	Pa men lant: jury		`4 ☐ Donation 5X Other (Specif		nt Grandv	iew Maus	1		-05	Johnst	own,	PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours eiter death with the Maryler Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licer	1590		22. Name and A	ddress of Faci	al Hom	ie_			
_	207 29		Dennis V-	Money	- 1	734 Be	dford :	St., J	ohnstov	vn, PA	15902	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not line.	enter the mode of	dying, such a	is cardiac or	respiratory arre	est,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lung	g Carcinom	a						Onset and Death Onths
	/Medical		resulting in death)	Due to (or a	s a consequence of):							
0	Examiner		Sequentially list conditions	b								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Calsector Light	Due to (or a	s a consequence of):							
	icate be executed physician end s the burial-transit	Examiner	that initiated events	c								
0	e exe ian e irial-	Ä	resulting in death) Last	Due to (or a	s a consequence of):							
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9	ng ph ng ph	0	IF FEMALE:									
Вох	th ce tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcom 1 Live birth	e of pregnancy 2 Fetal death	3 ☐Ectopic pregn	ancy			23d. Date Mor	of delivery	/ Day Year
	ed for	<u>S</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□ Unknown	at time of death	5 Other (specif	y)			MOI	iui L	yay real
P.0	that the death certificed by the attending I detached for use as	Physician/M	9 Unknown							1		
	es De	by	Part II. Other significant conditions of	ontributing to death	but not resulting in th	e underlying caus	e given in Part	t I.				cause of death?
Records,	w requir been si should	ted							1 L Ye	s 2 L No	3 Probat	oly 4 XUnknown
၁၀	lawr as be 2 sh	Completed							24a. Was as autops	24b. V	ere autops	sy findings available pletion of cause of
Ä	ilclan: The lav certificate has rector, page 2	mo;							perform	ned? d	eath? Yes 2	
Vital	lan: rtiflice stor. j	0	25. Was case referred to medical				26. Plac	ce of Death /	Check only on			
f V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1X Inpat	tient 2 ER/Outpa	tient 3 DOA	Other: 4 N	Nursing Home	e 5 🗌 Reside	nce 6 ⊡Othe	r (Specify)	
οι			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	jury 28b. Tim lay Year) Inju	e of 28c.	Injury at Work?	28	d. Describe ho	w injury occurre	ed	
Ö	Attending r death. sctor: After y the fune	atic	2 Accident investigation	1			1 Yes 2	No				
Division	l or Atten efter deatl Director: I in by the	tific	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	njury - At home, farm	street, factory, of	fice	28	f. Location (Sti	eet and Numbe . State)	r or Rural F	Route Number,
Ö	s efter al Director	Certification;		bonang, c	(0,000.7)			9	o.,	, 0.0.0,		
	ospil hour unar		29a. Certifier 1 Certifying Ph	ysicien: To the bes	t of my knowledge, d	eath occurred at the	ne time, date a	and place, an	d due to the ca	use(s) and mar	ner as stat	ed.
	To the Hospital or At within 24 hours efter of To the Funaral Direct completely filled in by	Medical	one)	and manner s	of examination and/o stated.	investigation, in i	my opinion, de	aui occurrec	ature ume, da	ne and place, a	na aue to ti	ie cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1.0	20	MO 29c. Lie	cense number		29	d. Date signed	(Month, Da	ay, Year)
	611.		(lut 1	N. ()1	1 Juston		39177			Octobe	r 7, 3	2005
1	2		30. Name and address of person who	completed cause of	death (item 23a) (Ty	pe, Print)						
L			Curtis W.	Ollayos,	MD 18101	Prince	⊬hillip ———	p Driv	e Olney	, MD 2	.0832	
	Sta	_	31. Date filed (Morth Car), Year) 2	005 32 Regist	trar's Signature	porte				· -		

		•	For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment tificate	of He	ealth a Death	and M		jien ę ()	05	3332	20
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of Dea Month OCT.		2005	3. Time of De	
	/Medic	al	DORIS M. MARANTO		ber)		4b. City, T	fown, or	Location of	of Death	001.	4c. Count		9:20	Α
	Examin	er	OAKCREST CARE C		50.7		BALT						LTIMO	RE	
	Funeral Director		5. Social Security Number 6. 216128444	Sex 1□MXXF	7. Ag <i>e (In yr</i> s. <i>I</i>	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov. 8,	Year)	9. Birthp Cour Mar	lace (State or Fi htry) y land	'oreign
pu	3		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation						1	0d. Inside City L	Limits
Maryla	ed at	jo	Maryland Baltime	ore			timor	e Co	unty					1 🗆 Yes 2	No
g c	r 28a-f	rect	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cour	ntry?	
th wit	23a o	aiD	8820 Walther Bl	vd. Apt.	3116			2123				US			
-0036 hours after death with the Marvland	"natural", or flems 23a or 28a-1 show edical Examiltar must be mutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Fore	2 X No		Was Decede fYes, speci 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, fy: Wh		
5-0 72 ho	2 4	Completed	15. Decedent's (Specify only highest of	Education trade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupa k done d	ition u <i>ring m</i> os	t of workir	ng	16b. Kind of B	lusiness/In	dustry	
121 within	giene. er than " Ine Mer	mpl	Elementary/Secondary (0-12)	College (1-			<i>DO NOT</i> us USEWi:)			Houseki	eenin	g~Own Ho	ome
d 2	rt Pag		12 yrs. 17. Father's Name (First, Middle, La	N/A	1	110	000111		18. Mothe	er's Name	(First, Middle,			g OWN IN	51110
<u>a</u>	D 0	To Be	Salvatore Gloric	oso					Ar	ngeli	na Culc	tto			
Maryland 21215-0036	. ल ल ह		19a. Informant's Name/Relationship Richard Maranto				-	•			letown,			Code)	
Baltimore,	nent of Health ant: If item 27 I ury or other tre		20a. Method of Disposition ★□ Burial 2 □ Cremation 3			lace of Dispo emetery, crer DOdlawi	natory or ot	her place	y]		-2005	20c. Location Baltimo			
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Light	oakn		22	. Namass 740.				Home Baltimo	re, Md	. 212	36	
	hysician /Medical xaminer		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (c	or as a consequent	cell uence of):			, such as		r respiratory an	est,		Approximate Interval Betwee Onset and Dea	en ath
8760, Ø	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Discass or injury that initiated events resulting in death) Last	с	or as a consequ										
Records, P.O. Box 687	by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 □ Fetai ent at time of de	death 3	Ectopic pre Other (spe						ate of delive	ery Day Yea	ir
rds, P.	in signed by	by	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	nderlying ca	luse give	en in Part I	l.	23e. Did to			ne cause of deat ably 4 □Unk	
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/ita	certifical rector, p	Be (25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o				
vision of Vita	this cral din	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time of			4 3 140		ne 5 🗆 Resid			y)	_
On	th. : After tuner	tion	1 Natural 5 Pending 2 Accident investigat	(Month	n, Day Year)	Injury	М	3c. Injury Work 1 □ Y	(? /es 2 ☐						
Divisi	after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could no determina	28e. Place buildin	of Injury - At ho g, etc. (Specif)	ome, farm, str	eet, factory,	, office		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number	r,
] Hospital	within 24 hours after de To the Funeral Direct completely filled in by the	edical C		Physician: To the aminer: On the ba and mann	sis of examina										
Tothe	withir To th comp	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date signe	ed (Month,	Day, Year)	
	7		a m	Lone	0	M.D	- 1)5	865	16		octobe	x 1	2,200	1
	10		30. Name and address of person when Anna Monia	5 89	100	wa	Print) 1+he		Bo	olevi	and 1	deku:	110,1	MO 217	L34
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 4 2005	Street 32. Re	egistrar's Signa	Coste									

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State of Maryland / Department of Health and Mental Hygier 1 1 5 33321 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Peggy P. McCann 2005 10 11 3:27 PM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air Harford 717 Claridge Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F Yrs. Tennessee Director 05/05/1930 413-44-1213 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or itema 23a or 28a-1 show traumatic event, the Medical Examinar must be multified at 1 ☐ Yes 2 No Directo Harford Bel Air MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 717 Claridge Court Funeral 21014 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Assembler Aerospace Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental is marked o Charlotte Louise Dula Thomas Pecktol 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) item 27 i 717 Claridge Court - Bel Air, Maryland 21014

of Disposition (Name of Date 20c. Location - City or Town, State other Lisa McCann (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permil. Pages Department of important: if it 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns.10/15/2005 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland 21087 assahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final -grade adenocavcinoma **Physician** le months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, harry, bearing to minimodal a cause. Enter Underlying Cause (Disease or injury Directo (or as a nonsequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. P ed by the a detached f cate has been signed by , page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 200 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death efter death Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral I 1.4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little certif ending Surgeon D39104 on who completed cause of death (Item 😁) (Type, 30. Name and address of per-Blalock 604 Baltimore Maryland Kurt Campbell 600 North Wolfe State

Registrar

Began Butch Missovei

Please Type or Print in Black Inde	elible Ink. Ensure All	Copies Are Legible
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State of Maryland / Department of Health and Mental Hygien 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Missouri Month Dav Butch October 9, 2005 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2112 Emmorton Park Road Room 101 Edgewood Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1∭M 2□F Director 177-40-5235 53 June 19, 1952 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or itams 23a or 28a-f show traumatic event, Ind Mudical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ➡No Maryland Harford Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2112 Emmorton Park Road Rm 101 21040 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Missouri Butch Bogan (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau QDC8. Sharon Missouri - Wife 2112 Emmorton Park Road, Rm 101, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Fernwood Cemetery 10-15-05 Fernwood, Pennsylvania 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications hat laveled shock, or heart failure. List only one law e on each lin ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician periampollary disease or condition resulting in death) Cances Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. eq Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Kunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate 1 Yes 2 No 1 ☐ Yes fo the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MO 04057802 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buydowny Baltimore Maryland 21231 Messessmith MD 401 North 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar 4 2005 freede

State of Maryland / Department of Health and Mental Hygien 2005 33323 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year BETTY MICICHE 9:50 OCTOBEL /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Homewood Center **Baltimore** N/A 8. Date of Birth (Month, Day, Year) March 26,1941 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F 217-38-7280 64 Yrs. Director Mary1and Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic svent, the Madical Examiner must be notified at Director XXYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1525 W. 36th Street 21211 USA or Items 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KINO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: à Specify: 3 X XVidowed 4 □ Divorced white naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other treumatic event, If all once. Homemaker In own home unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter A. Dunnigan Sara Flora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 3505 Buena Vista Avenue William Miciche, Jr. Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Gardens of Faith 10/14/2005 | Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211 21. Signatur Ineral Service Loens 23a. Pact. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CIRROSIS THE LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entail Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death Day Year 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred Division After 1 Natural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hc To the Fun completely i 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1006 1789. 2005 σ_{l} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OFORI-ANUAH, 5001 LOCA RAVEN BLVD, BALTIMORE LOPPAINE MD 21239 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State o		artment of Health and rtificate of Death		71115	33324
			Decedent's Name (First, Middle	9, Last)		undate of Boath	2. Date of Death	g. NO.	3. Time of Death
	Physic		Ualton C Ma	1 - 4			Month	Day Year	
	/Medi Exami		Walter S. Mo 4a. Facility Name (If not institution		nber)	4b. City, Town, or Location of Dea	Oct.	0, 2005	
	⊏xamı	ier					itn	4c. County of Dea	
			Future Care C 5. Social Security Number	anton Ha		Baltimore If Under 1 Year If Under 24 Hr.		n/	
	Funeral Director		216-07-6614	1.XXM 2□F	7. Age (In yrs. last birthday) 87 Yrs.	Months Days Hours Min	. (Month, Day,)	rear) C	thplace (State or Foreign ountry)
		ļ	Usual Residence of Decedent		0 / 113.		1/ 13/	/18 Ma	ryland
	land		10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary F sh	ō	361	,					1 📆 Yes 2 🗆 No
	the /	ect	10e. Street and Number	n/a	ва.	ltimore			
	with a o	Funeral Director				10f. Zip Code	100	g. Citizen of What C	ountry?
	s 23	ra	525 S. Kenw			21224		USA	
	after deat or Items	un	11. Marital Status	Armed Fo	rces?	Was Decedent of Hispanic Origin? () f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
36	ours after death with the Marylan al', or Items 23a or 28a-f show Exeminer must be notified at	by F	1 Never Married 2 Marr	If Yes, Giv	е	1 ☐ Yes 2 ☒ No Specify:		Specify:	, 0.0.
21215-0036	,72 hours after death with the Maryland "natural", or Items 23a or 28a-f show officel Exeminer must be notified at		3 Widowed 4 Divorced	Year or Da	ates:			apacity.	White
5	d within 72 ho piene. r than "natui ire Madical	Completed	15. Decedent (Specify only highes	st grade completed)	(Give	lent's Usual Decupation kind of work done during most of we	orking 16	3b. Kind of Business	/Industry
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2	illed with Hygiene. Other than		12 Fathada Nama (First Middle	3_	Mecha	anical Engineer		<u>Bendix-</u>	Allied
E	tal o b	Be	17. Father's Name (First, Middle,	,			me (First, Middle, Ma	uiden Surname)	
1	should be nd Mental marked o	은		gowski			phine		
Maryland	2 sho and lam		19a. Informant's Name/RelationsI			g Address (Street and Number or R	ural Route Number, (City or Town, State, .	Zip Code)
	s 1 and 2 should f Health and Mer item 27 la marke other traumatic		Donna Buttke	/ Daugh	ter 508	S. Kenwood Av	e. Balti	more. M	1. 21224
ore	ges 1 it of H if item or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Demoved from	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date 20	c. Location - City or	Town, State
Ĕ	Pag nent int: I		'4 □Donation 5 □ Other (S)		state	Cemetery 10	/14/05 B	altimore	Md.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service I	_icense	22	Name and Address of Facility Kaczorowski F	714705 5	arcimore	, riu.
m	Depa Impo any ir		Curina	16		Raczorowski F 2525 Fleet St	uneral H	ome P.A.	01007
			23a. Part1. Enter the disease, or	complications that ca	aused the death. Do not ente	or the mode of dying, such as cardia	c or respiratory arrest	ore, Ma.	21224 Approximate
No.	Physician /Medical		Immediate Cause (Final	only one cause on ea	ich line.	· ·			Interval Between Onset and Death
			disease or condition resulting in death)	a	or as a consumence if);	313			years.
	Examiner			Due to (or as a consequence ():	Heart failing			1.100
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y	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		ir as a consequence of):	U			V
	xecu and al-tra	xar	that initiated events resulting in death) Last	c. Due to (c	or as a consequence of);				
68760,	ficate be executed physician and s the burial-transit	ai		·					
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_			IF FEMALE:	23c If was outs	ome of pregnancy				
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.O.	that the death cer ed by the attendin detached for use	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		Other (specify)			Day Tour
	hat t	Ph	Part II. Other significant condition	ns contribution to de	ath but not regulting in the un	dashina sawa awa is Dast I	On Didasts		
Vital Records,	ed be	by		no contributing to de	an partior resulting in the an	deriying cause given in Part I.			the cause of death?
5	w requir been s should	Completed					1 🗆 Yes	2 □ No 3 □ Pro	obably 4 \Unknown
ခ	has b	ple					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
=	ysician: The is certificate hadirector, page	Ö					performed	d? death?	
Į į	i iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		- 0
	Physic this o	ဥ	1 ☐ Yes 2 No	Hospital: 1 □ In	patient 2 ER/Outpatient	3□ DOA Dther: 4 Nursing H	lome 5 🗆 Residence	e 6 □Other (Spec	rify)
_	Attending Physician: or death. ector: After this certifice by the funeral director, it		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of (Month)	Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		,
0	endi sath. or: A he fu	atle	2 Accident investig	ation		M 1 ☐ Yes 2 ☐ No			
Division of	or Attendation of the death Director: in by the	Ĕ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 289. Place	of Injury - At home, farm, stre g, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,
	tal o rs aft al Di ed in	Certification:			g, etc. (epochy)		Oily of Town, 3	iaie)	
	hou uner uner		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the t	est of my knowledge, death	occurred at the time, date and place	, and due to the caus	e(s) and manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	one)	and manne	sis of examination and/or inve	estigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To with	Σ	29b. Signature and title of certifie			29c. License number	29d.	Date signed (Month	. Day, Year)
			Stanf. 1	how from, m	DIFACY	D 51088	Oc	tober 12,	2005
	0		30. Name and address of person w	ho completed cause	ohdeath (Item 23a) (Type. P	rint)			
	•		Than Poon	384 St.	Pan Place.		wy, m) a	11212	
	Sta	è	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signature	19		7 7 7 1	
	Registra	ar	OCT 1 4 2	2005	we to hose	Es .			

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hyg Certificate of Death	ilene2005 33325
	Physici /Medi		1. Decedent's Name (First, Middle, La	NURTEET 2. Date of Deat	10 8 2015, 7:50 R
	Examir	ner	4a. Facility Name (If not institution, given	b street and number 1 1 4b. City, Tayun, or Licication of Death About 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4c. County of Dealth
	Funeral Director		5. Social Security Number 6. S Usual Residence of Decedent	Sex 7. Age (Ip yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,	Year) 9. Birthplace (State or Foreign
	e Maryland a-f show iifjed at	ctor	10a. Stafe 10b. County	10c. CHYTOWN or Location BALLIMORE	10d. Inside City Limits 10 es 2 ☐ No
	ath with the 23a or 28	ral Director	10e. Street and Number Bet	nel Coulet 2/202	og. Citizen of What Country?
5-0036	oursafter de ral', or Items Examiner p	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White-etc
21215-0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Experimet must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		1860/Kind of Business/Industry
Maryland	should be filed with nd Mental Hygiene. I marked other than umatic event, I a la	To Be	17 Father's Name (First, Middle, Last	ON NOW /18. Mgther's Namer (First, Middle,)	laiden Súiname)
	1 and 2 sho Health and I tem 27 is ma		19a. Informant's Name/Relationship 20a. Method of Disposition	Type, Print) 19b, Mailing Pettress (Str) et and Number of Rural Roste, Number, 20b, Place of Disposition (Name of Date	City or Town, State Zib ode) 20c. Lot stion or T - n. State
Baltimore,	Page nent o nnt: If ury or		T Surial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service Licer	Removal from State (Camptery, arematory prother place)	20c. Lo. stion or T / n, State
Ba	permit. Departrimports any inju		> Cepthia	Sharmer 1300 N. CEDERAL A	VE. 1 3416 M. Wall
	Pnysician /Medical		23a. Part1. Enfer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Programe Dechne	st, Approximate Interval Between Onset and Death
ł	Examiner		Sequentially list conditions,	b. I Sehoumu ly Wers	
	cuted nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c. Old who wanted Harm	mhge
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of):	
O. Box 6	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
ds, P	ires that signed b	by	Part II. Other significant conditions of		acco use contribute to the cause of death?
Division of Vital Record	aw Is b	ompleted	Remen	n Oraen 24a. Was an autopsy	24b. Were autopsy findings available
tal R	ate pag	ပ	25. Was case referred to medical	perform 1 yes 2	☐1Ño 1 ☐ Yes 2 ☐ No
of Vi	dis ys	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Norsing Home 5 Resider	nce 6 □Other (Specify)
sion	ftei ine	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		v injury occurred
Divis	o it to	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street, factory, office) City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funeral Completely tilled in	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dat and manner stated.	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29c D 3 (Y + Y	d. Date signed (Month, Day, Year)
•	7		30. Name and address of person who		10/11/03
	Sta	te	31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Type, Print) HAS ITM MD S21 N , EUTAW ST Smite 3 37 Registrar's Signature	50+ isalhrax MI)
	Registr		OCT 1 4 20	US ROBERT ST REPORTED	

			For State	State of Ma	aryland / De	partment of <i>ertificate of</i>	Health and N f Death		giene 005	33326
	T 2		Registrar 1. Decedent's Name (First, Middle, Last)		ertinicate of	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physic /Medi		Albert A. N	owicki,	Sr.			October	8, 2005	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of De	
a.		x! . E	Greater Baltimor			Towson			Baltimor	
	Funeral Director		216-12-9119	MM 20E	83 Yrs	Months Days	s Hours Min.	8 Date of Birth (Month, Day Feb. 1	, Year) 9. B , 1922 Ma	rthplace (State or Foreign Country) ryland
	iand iand		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Marylar I-f show	ţ	MD Baltime	ore	Reist	erstown				1 ☐ Yes 🏋 🏋 No
\	th the M or 28a-f	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
t	23a c	a C	406 Homevale	Court		2	21136		U.S.	Α.
1 bert	urs after death with the Marylis al', or Iteme 23a or 28a-f shor Exanither must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 Never Married Married 3 Widowed 4 Divorced	1 ☐ Yes XXX N If Yes, Give Year or Dates:	10	1 ☐ Yes XXN	o Specify:		Specify:	T.TL 4 L _
73	within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28s-f show the Madical Exemiter match propfilled	ted	15. Decedent's Edu	cation	16a. De	ecedent's Usual Occu	upation		16b. Kind of Busines	White s/Industry
215	thin 7	Completed	(Specify only highest grad	College (1-4or 5	+)		e during most of work red)	ung		
2 کے د	_ = _ = _	S	7			Dock Wo			Ship	ping
and A	ed at a S	Be	17. Father's Name (First, Middle, Last) Michael Joseph	Novide	4				Maiden Sumame) iniecki	
	s 1 and 2 should Health and Men tem 27 is marke other traumatic	ပ	19a. Informant's Name/Relationship (T)			ailing Address (Stree			r, City or Town, State,	Zin Code)
3 ₹	1 and 2. Health ar em 27 is		Mary W. Nowick	ci / Wif	140				stown, M	
	of Hei	1 2	20a. Method of Disposition XXBurial 2 Cremation 3 F	,		sposition (Name of crematory or other pla			20c. Location - City o	
<u>≅</u>	Pag ent ent nt: I	١.,	4 □ Donation 5 □ Other (Specify)			nts Ceme	tery 10	/14/05	Reisters	stown, MD
N Baltimor	Departm Departm Importa eny Inju		21. Signatur Fineral rvice Licens	88		22. Name and Addr	ress of FacilityECK	hardt E	Tuneral C	hapel P.A.
	40 = 0		220 Ports Enter the disease or come	m						1s,MD21117
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	10.	·				Approximate Interval Between Onset and Death
91	Physician /Medical		disease or condition resulting in death)	a. / 1/27	a consequence of):	C HUP	nocacii	noma		
	Examiner				a consequence on:					
	7 =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):					
H	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	3.						
60,	icate be executed physician and the burial-transit	aj E	rosaning in osani, Last	Due to (or as a	a consequence of);					
68760,	g physias the	edicai		d						
Вох	eath certil attending for use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy				23d. Date of de	livery
Ö	ne death the atte hed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at 9☐Unknown		3 □Ectopic pregnand 5 □ Other (specify) _	cy		Month	Day Year
0.	that the deed by the detached	Phys	9 Unknown							
Division of Vital Records, P.O.	Se Co	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did tot	bacco use contribute t	o the cause of death?
Sor	w requir been si should I	etec	BOINGLOL	chaus	hin					
Rec	he lav e has	Completed	100000	J PPIUC.	104			24a. Was a autops perforr	v prior to	utopsy findings available completion of cause of
重	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Deatl		No 1□Ye	5 2 No
<u>></u>	Phyeici this cer al direc	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatier	nt 2 ER/Outpa	tient 3 DOA	h		ence 6 □Other (Spe	ocify)
0 [ding Pt h. After th funeral		27. Mannur of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tim Yea <i>r)</i> Injui				ow injury occurred	
Sio	ttendi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 81 111]Yes 2∏No			
.=	- e	Certification:	4 Homicide determined	building, etc	. (Specify)	street, factory, office		City or Town	reet and Number or R n, State)	ural Route Number,
	spita hours ineral y fillec		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowledge, de	eath occurred at the t	ime, date and place,	and due to the ca	ause(s) and manner a	s stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	one)	and manner sta	examination and/o	investigation, in my	opinion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	100.0	1 110	29c. Licen	se number	2!	9d. Date signed (Moni	h, Day, Year)
	T		VIITCHU	telle	(IN)	15	4418		10-9-	2005
	10		30. Name and address of person who co	mpleted cause	eath (Item 23a) (Typ	(GC/A)	Mead-	CH	Cto 1-17	DIZMIND
· ·	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	10770,(UNU		1000	21204
	Registr	-	OCT 1 4 200	5 Algua	J. B. A	parte				

			1 - For State Registrar	tate of Maryland /	Certific	ent of H ate of L	ealth and I Death		jiene () (J 5	33327
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Milton Lewis	Parker				2. Date of Dea	er ^{Da} y, 2	กฬร	3. Time of Death 4:55 PM M
O 8	Examir	er	4a. Facility Name (If not institution, give stree Joseph Richie Hos			ity, Town, or Baltin	Location of Death	1	4c. County	of Death	
2	Funeral Director	2.43	5. Social Security Number 577-48-3998 6. Sex 1 № M	7. Age (In yrs. last bi	Yrs. If Un Mont	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 124y	Ye1/936	9. Birth	place (State or Foreign g 'Ynia
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince Geon		vn or Location						10d. Inside City Limits 1 ☐ Yes 2 🛂 No
	death with the Maryland me 23a or 28a-f show fritted by ricilling at	Funeral Director	10e. Street and Number 105 Firethorn Court	_	10f.	Zip Code	774		0g. Citizen of V	What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Mudical Examinational be multiped at once.	þ	1 Never Married 2 Married	Was Decedent Ever in U.S. Amed Forces? I BYes 2□11-24-54 If Yes, Give 10-10- Year or Datets: 0 10-10-	4 1 Va	cedent of His pecify Cubar 2 No		pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	k, White	ican Indian, , etc. lack
215-0	thin 72 ho e. an "natur	Completed	15. Decedent's Education (Specify only highest grade co		Decedent's U (Give kind of life. DO NO		tion uring most of wor	king	16b. Kind of Bu		-,
Ind 21	be filed winted Hygien of other the	Be	12 17. Father's Name (First, Middle, Last) George Stuart		Electr	ician		ne (First, Middle, I Jackson			nting Offic
Maryland 21215-0036	id 2 should th and Mer 27 is marke traumatic	To	19a. Informant's Name/Relationship (Type, Ethel N. Parker - N	Print) 196	b. Mailing Addr	ess (Street a	nd Number or Ru	ral Route Number	; City or Town, 20774	State, Zi	p Code)
Baltimore,	Pages 1 ar nent of Hea nt: if item ? rry or other		20a. Method of Disposition 1		of Disposition (ery, crematory (ico Nat		n. 10-1		20c. Location -		
Balti	permit. Departm Imports eny Inju		21. Signature of Funeral Service Licens	ndll l	2566	2 A.P.		Lvd Port		VA :	22535
	Physician /Medical		23a. Pant. Enler the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ons that caused the death. Do ause on each line. MULTIPLE Due to (or as a consequence	146		, such as cardiac	or respiratory arre	est,	(Approximate Interval Between Onset and Death
13 J	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence							
600,	tificate be executed ig physicien and as the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a consequence	of):					-	
68760,	artificate ing phys e as the	Medicai	d.								
10/5 0. Box	requires that the death certificate een signed by the attending physi nould be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy Live birth	3 □Ectopic 5 □ Other	pregnancy (specify)			23d. Date Mor		ery Day Year
ecords, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributed by the significant conditions contributed by the significant conditions are significant conditions.		in the underlyin	g cause give	n in Part I.	23e. Did tob		ibute to t	he cause of death?
Ket	\$ D 00	Completed						24a. Was an autops perform	y p	rior to co	opsy findings available impletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	tal			_	th (Check only on	9)		
on of	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	10103 20110	Ba. Date of Injury 28b.	Time of Injury	28c. Injury Work	4 Nursing no	ome 5 Reside 28d. Describe ho			N) HOSPICE
Holy Divis	tel or Atters after des al Director ed in by the	Certification:	2 Could not be	Be. Place of Injury - At home, fa building, etc. (Specify)	arm, street, fac	ory, office		28f. Location (St. City or Town	reet and Number, State)	er or Rura	al Route Number,
MI	To the Hospitel or within 24 hours after To the Funeral Dirticompletely filled in it	Medical	one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination an and manner stated.	e, death occurr nd/or investigat	ed at the time on, in my opi	e, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and mai ate and place, a	nner as s and due to	tated, o the cause(s)
	Tol	7	29b. Signature and title of certifier	$m \circ a$		29c. License			d. Date signed		
	7/2		30. Name and address of person who comple	oted cause of death (Item 23a)	(Type, Print)	000	22488		10-5	-05	
			LYDIA M. JUM	32. Registrar's Signature	P. 1; 200	O TUK	BRIDGE	ROND; E	NAMOR	E. P.	10,2/2/2
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 4 2005	32. Registrar's Signature							

Certificate of Death

4b. City, Town, or Location of Death

Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 2. Date of Death

October

8. Date of Birth (Month, Day, Ye Jan. 15.

12,

2005

Montgomery

1949 California

Race - American Indian, Black, White, etc.

Specify: White

Agency

23d. Date of delivery

29d. Date signed (Month, Day, Year)

October 13, 2005

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

4c. County of Death

Month

Leser

32. Registrar's Signature,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#105

7. Age (In yrs. last birthday)

56

3. Time of Death

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Six Years

Year

1 ☐ Yes 2X No

5:40P M

33328

Physician /Medical Examiner

Funeral

Director

1 - For State Registrar

5. Social Security Number

566-80-3190

Decedent's Name (First, Middle, Last)

Timothy Hull Pinkham

4a. Facility Name (If not institution, give street and number)

1**⊠**M 2□F

6445 Rock Forest Drive,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and tiple of certifier

Cheryl A. 31. Date filed (Month, Day, Year) 29c. License number

D54378

Aylesworth, M.D. 6410 Rockledge Drive #625, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Easure All Copies Are Legible. Amend item#1, State of Maryland/Department of He and Mental Hygiene 33329 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Ricky Edward Reihl 2. Date of Death 3. Time of Death Physician Month Yeer 2005 OCT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ef Maryland Medical center University Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 3-31-1951 **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F 216-52-6098 54 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at MD Baltimore N/A1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 3219 Rosalie Rd. Itema 23a 21227 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No
If Yes, Give 9-17-19-10
Year or Dates 9-21-19-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 ☑ No þ Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *nt any injury or other traumatic event, Ita Medis once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automobile 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Carroll B. Reihl Emma Ma Wells ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Muller/Sister 2011 Smith Ave. Halethorpe MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 10-6-2005 Baltimore, MD Surreture of Funeral Service Name and Address of Facility
Aubrose Funeral Home of
Autrose Funeral Home of
Autropean Rd. Lansdowne MD 21227 23a. Patt. Enter the disease or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Dav 5 Other (specify) ed by the a O 9 Unknown 9 Dunknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, should I 4 Wunknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? certificate hes t irector, page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Impatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division s after dec. 5 Pending Injury 2 Accident investigation 1 TYes 2 TNo 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge death octured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18543 oct 2,2005 completed cause of death (Item 23a) (Type, Print) 30. Name and address of Greene Street Baltimore, MD 2120 Angelo 31. Date filed (Morth, Day, Year) 32. Regi war's Signature State Registrar

hysic		1. Decedent's Name (First, Middle, La Elizabeth Irene	,		rtificate c	. Doutt	2. Date of De Month	Day	Year	3. Time of Death
/Medi xami		4a. Facility Name (If not institution, gir			4b. City, Town	n, or Location of D	10	11 2 4c. Count	2005 v of Death	09:00p
		Fox Chase Nursi	ng Home		Silve	er Spring	r		itgome	rv
neral ector			Sex 7. Age (In 1	yrs. last birthday) 89 Yrs.	If Under 1 Ye Months Day	ar If Under 24 I		h y, Year)		ace (State or Forei
2		Usual Residence of Decedent 10a, State 10b, County	100	City Tarres			05 10			
9 2	5	Tob. County	100	City, Town or Lo					10	Dd. Inside City Limi
28a-1	Director	10e. Street and Number		Washing						1 x Yes 2 □ N
23a or	ral Dir	517 Aspen St. N	W		10f. Zip Code	20012		10g. Citizen of t	What Count	try?
importent: I tem 27 is marked other then hauder, or feme 2as of 28s-1 show any injury or other traumetic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1Yes 2XNo If Yes, Give Year or Dates:		Was Decedent of f Yes, specify C 1 ☐ Yes 2 🖾 N	uban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	Bla	ck. White, e	etc.
De Co	eted	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occ	cupation		16b. Kind of B	usiness/ind	ustry
¥	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of ired)				
4				Mana	gement	Speciali			rment	
tic even	To Be	17. Father's Name (First, Middle, Last William Carroll	•				Name <i>(First, Middle,</i> E11en Hu		n <i>e)</i>	
	0	19a. Informant's Name/Relationship (** *				Rural Route Numbe			Code)
her tr		John N. Nichols	***			St. NW	Washingto	n DC 20	011	
or of		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		 Place of Dispo cemetery, cren 	sition (Name of natory or other p	· ·	Date	20c. Location -	City or Tow	vn, State
Jury		4 Donation 5 Other (Special	(y)	Chesapea		-	0-14-2005	Belts		MD
any tr		21. Signature of Funeral Service Lice	2 MO	1330	933 Gis	t Ave Si	Cremation lver Spri	no MD 21	e 0910	
	` ,	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not ente	er the mode of d	ying, such as card	liac or respiratory are	est,		Approximate Interval Between
ician		Immediate Cause (Final disease or condition	Advanced	Dementi	а					Onset and Death
dical niner		resulting in death)	Due to (or as a con	sequence of):						
illiei	_	Sequentially list conditions, if any, leading to immediate	b							
Sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	Sequenna of):						
il-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	isacijance of):						
buria	al E		200 10 (0. 00 2 00.	ooquanos on.						
is the burial-transit	edical		_ d							
or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	23c. If yes, outcome of pre 1☐Live birth 2☐F 4☐Pregnant at time	etal death 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date Mor	e of delivery	/ Pay Year
tech	h	9 Unknown	9□ Unknown							
should be detected to	۵	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying cause g	iven in Part I.				cause of death?
2 sho	plet						24a. Was a	n 24h V	Vere autons	y findings available
age	Completed						autops pertor	ned? p	rior to compleath?	y findings available detion of cause of No
<u>-</u>	Be	25. Was case referred to medical examiner?	Hospital:		10	thor	eath Check only on			
ector,	<u>و</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 L Inpatient	2 ER/Outpatient 28b. Time of	JLI DUA		Home 5 ☐ Reside			
al director.	5	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) Injury	28c. lnji W		28d. Describe ho	w injury occurre	9d	
al director.	ĕ∣	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, stre]Yes 2 □No	28f. Location (St City or Town	reet and Numbe	er or Rural F	Route Number,
n by the funeral director.	rtification	4 Homicide								
n by the funeral director.	i Certification;	4 [] Notificide			occurred at the	ime, date and place	ce, and due to the ca	use(s) and mar	ner as state	ed
ely filled in by the funeral director.	O	29a. Certifier 1 ★ Certifying Ph	ysician: To the best of my	knowledge, death iination and/or inve	estigation, in my	opinion, death oc	curred at the time, di	ate and place, a	nd due to th	ne cause(s)
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pletely filled in by the funeral director,	ledical C	29a. Certifier (Charanty one) 29 Medical Can	iliter. On the basis of exam	knowledge, death	29c. Licer	opinion, death oc		9d. Date signed	(Month, Da	ne cause(s)
ely filled in by the funeral director.	Medical C	29a. Certifier (Charter) (Chart	and manner stated.		29c. Licer	opinion, death oc			(Month, Da	ne cause(s)
ely filled in by the funeral director.	Medical C	29a. Certifier (Charanty one) 29 Medical Can	and manner stated.	Item 23a) Type, P	29c. Licer M	opinion, death occurse number 058597	2	9d. Date signed	(Month, Da	ne cause(s)

			State of State Registrer	Maryland /	/ Depa	artment tificate	of H	ealth a	ind M	ental Hy	gienę	2005	33331	
	Physici	an	1. Decedent's Name (First, Middle, Last) Stephen Reiter	-						2. Date of Dea	of 5 y	2005	3. Time of Death 06:43pm	
	/Medic Examin		4a. Facility Name (If not institution, give street and num. Suburban Hospita1	ber)			rown, or ethe	Location o	f Death			County of Dea Montgo		
	Funeral Director		001 30 4030	. Age (In yrs. last 55	birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da 05-16-	h y, Yea <i>r)</i> -1950	9. Bin Cc N	thplace (State or Foreign ountry) ew York	
	nand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation							10d. Inside City Limits	
	e Man	ctor	MD Montgomery	Roc	kvil								1 □ Yes 2X No	
	with th	Dire	10e. Street and Number 6105 Montrose Rd			10f. Zip	Code	208	52		-	zen of What Co JSA	ountry?	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic avant, it a Mudical Examinar must be notified at	by Funeral Director		2€]No		Was Deced				ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: W		
Maryland 21215-0036	within 72 hour sene. then "neture!	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	1	(Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition furing mosi)	t of worki	ing		nd of Business		
121	iled wi tygien ther th		17. Father's Name (First, Middle, Last)		Cou	rier		18. Mothe	r's Name	e (First, Middle,			Service	
lanc	ld be filental h kad ot Ic avai	To Be	Abraham Reiter							Franci				
Mary	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other than " ir traumatic avent, it a Mer		19a. Informant's Name/Relationship (Type, Print) Hayden E. Reiter/brother		330	Lori	Cir	cle,		key TN			Zip Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tra once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) King Solomons Memorial Gardens 10-09-2005									fton,	Town, State New Jersey	
Balti	permit. Departmingoria any inju		21. Signature of Funeral Service Licensee Memorial Gardens 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.											
3760,	death certificate be executed By Aman Be ettending physicien and and dior use as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Immediate Cause (Chr. Due to (conditions))	used the death. I chiline. piration or as a consequent or as a conseq	Pneu nce of): nal F nce of):	monia		g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
P.O. Box 68	w requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the buriat-transit	by Physician/Medi	23b. Was decedent pregnant	ome of pregnancy th 2 Fetel de ant at time of deat	ath 3[∃Ectopic pr] Other (sp					2	23d. Date of de Month	llivery Day Year	
	requires thet the sen signed by th nould be detache	d by Pl	Part II. Other significant conditions contributing to de	ath but not resultin	ng in the u	inderlying c	ause give	en in Part I			obacco u Yes 2∱		o the cause of death? robably 4 ☐Unknown	
Division of Vital Records,	The lar	Completed								24a. Was autoj perio 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				Othe			h (Check only o				
n of	ng Phys Iter this	on: To	T Yes ANNO		VOutpatie Bb. Time o Injury	of 2	8c. Injun	at c?		me 5 Resi 28d. Describe			ecify)	
Divisio	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 2 Accident of Could not be determined of Homicide of Homicide of Could not be building, etc. (Specify) M 1 Yes 2 No 281. Location (Street and Number or Rural Route Number of Town, State)									lural Route Number,		
	na Hospita n 24 hours na Funaral	Medicai C	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba and mann	sis of examination										
	To t withi com	Σ	29b. Signature and title of certifier Mulus Mlas		vel			4722				e signed (Mon 0-06-20		
	1		30. Name and address of person who completed caus Melissa Means-Markwell 1	of death (Item 2: $4D - 8600$	3a) (Type 01d	Print) Georg	getow	n Rd	. Bet	thesda,	MD			
	St Regist	ate rar		ar's Signatur	Α									
			UL 1 4 6003		-									

			1 - For State Registariend Item #	State of Maryla	nd / Depa 3_ 10/21	artmer <i>rfifica</i>	nt of H	ealth a Death	nd M	lental Hy	Reg. No.	2005	3 3 3 3 2
	Physici /Medic	al	Charles Edward F	Richmond				Location of	(D 1 h	Month 10	Day 11	2005	8:00 AM M
**	Examir	er	4a. Facility Name (If not institution, giv. 9318 Shadycreek 5. Social Security Number 6. S	Way ex 7. Age (In yrs	. last birthday)	Ba If Unde	ltimo	ore	24 Hrs.	8. Date of B		County of De Baltim 9. B	
\$5.	Director	9	219-52-6078 Usual Residence of Decedent	X ^{M 2□ F} 47	Yrs.	Months	Days	Hours	Min.	06/09			aryland
	h the Maryland r 28a-f ehow Localised at	Director	10a. State 10b. County MD Baltin		ity, Town or Lo altimor	re							10d. Inside City Limits 1 Yes 2 No
0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-f ehow dicel Exacilizational te notified at	by Funerai	9318 Shadycreel 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Dece If Yes, spe	2 X No	Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	U.	Black, Wh Specify: Wh	nerican Indian, lite, etc.
9500-6121	within ene. than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		life.	DO NOT	ork done d use retired	durina most		ing	Bal		s/Industry County Education
Maryland 2	be filed tal Hyg d other event,	To Be Co	17. Father's Name (First, Middle, Last, Kenneth L. Richn	_	Stati	IOHAL	у гле	18. Mother	's Name	e Cleo	e, Maiden Wilk	Sumame)	<u> </u>
бащтоге, магу	ermit. Pages 1 and 2 should epartment of Health and Men nportant: If Item 27 is marke ny injury or other treumatic n <u>ce.</u>		19a. Informant's Name/Relationship (Donna J. Richmo 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Licen	ond (wife) 20b. Removal from State W Me	9318 Place of Dispo cemetery, creater Creater	Sha osition (Na omatory or emato 2. Name a	dycre	eek Wa	ay - 0/1	Baltin 4/2005 F. Las	Bal	timore Funer	and 21234 or Town, State , Maryland al Home, P.A.
8700,	death certificate be executed Be attending physician and morn of cruse as the burial-transit and property and property of cruse as the burial-transit and property of cruse as the burial-transit and property of cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the burial-transit and property of the cruse as the crus	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):		de of dying	g, such as o	ardiac c			, Mary	Approximate Interval Between Onset and Death
O. BOX 6	the death certify the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic p ⊒ Other (s						23d. Date of d Month	elivery Day Year
Ž.	The law requires that the de te has been signed by the a rage 2 should be detached f	by	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	underlying	cause give	en in Part I.					to the cause of death? Probably 4 Unknown
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=	ysiciar is certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	7500		Othe	-		(Check only			
on of	ding Phy h. After this funeral d	—	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	4 LI Nur		me 5 Le Res 28d. Describe		Other (Sp y occurred	ecify)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At i building, etc. (Spec	nome, tarm, sti	reet, facto	ry, office			28f. Location City or To	(Street an own, State	d Number or I	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier 1 1 € Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred ivestigatio	at the tim	ne, date and pinion, deat	l place, a	and due to the ed at the time	, date and	place, and du	ue to the cause(s)
	With Tot Com	M	29b. Signature and title of settier			29	D 2	2263	-2			e signed (Moi	nth, Dey, Year)
	1,2		30. Name and address of person who Dr. S.S.RINIVAS	completed cause of death (Ite	m 23a) (Type,	BLVD	BA	LTIM	ore	MD.	2123	9.	
\$ 5 \$6 \$40	Sta Registr		31. Date filed (MDVC Pay 1 Year) 20	05 Registrar's Sign	ature de	de							

			State of Maryland / Department	rtment of H	ealth and Me	ental Hygi	en 2005	33333
			Registrar 1. Decedent's Name (First, Middle, Last)	ilicale of L		Ree	g. No.	3. Time of Death
п	Physici		Charles Lloyd Reynolds			Month October	Day Year	
	/Medic Examin			4b. City, Town, or	Location of Death	occoper	10, 2005 4c. County of Death	11:00 a ^M
	LAdillii	ic.	119 St. Mary's Church Road	Abingdo			Harfor	
	Funeral	9-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	B. Date of Birth	9 Birth	place (State or Foreign
	Director		213-46-1719 60 Yrs.	World Days	riodis Will.	(Month, Day, 1 July 3,	1945 Mary	
	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits
	Maryl f eho	ŏ	Maryland Harford Abingdon					1 ☐ Yes 2 ☐ No
	28e	rec	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cou	intry?
	h with	Funeral Director	119 St. Mary's Church Road	2100	09		USA	•
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of His	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No-	14. Race - Ameri	
36	or Its	y Fu	1 ☐ Never Married 2 🚰 Married 1 ☐ Yes 2 🚰 No	☐ Yes 2⊠ No	Specify:	ioan, etc.)	Black, White Specify:	, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itame 23s or 28e-f ehow than "natural" or Itame 7.8 Medical Examinar must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decede					
5	in 72 in 72	ojete	(Considerable highway am do namelate d) (Circa L	ent's Usual Occupa kind of work done d OO NOT use retired)	harima manada ad saadain.	7 T	6b. Kind of Business/Ir ndustrial	Equipment
212	l with jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Distriction Vice I	ict Sales President	5	M	anufacture	r
	a filed of he vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	First, Middle, Ma	aiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itame 23s or 28e-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	To	Charles Oscar Reynolds		Martha	(nmn) l	Mannoni	
Jar	2 sho	5					City or Town, State, Zi	
	1 and 1ealth om 27 ther t				Da Da		ingdon, MD	
Baltimore,	ages or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	atory or other place	9)	//:	Oc. Location - City or T	
三	iit. Partmer artmer ortant njury		4 □ Donation 5 □ Other (Specify) Hilltop Se 21. Signature of Funeral Service Licensee 22.				owson, Mar	y1and
Ba	Depar Importany it		Alle Mongo Don't	COMAS Fu	s of Facility ineral Hom sbury Road	e, P.A.	don, Maryla	21000
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart-failure. List only one cause on each line.	r the mode of dying	g, such as cardiac or	respiratory arres	it,	Approximate
	Pnysician		Immediate Cause (Final	Cane	0			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	010/0				6 140.17.13
	Examiner		Sequentially list conditions, b. Due to (2003 2 2003 2003 2003 2003 2003 2003 2					
7	pı is	iner	cause. Enter Underlying					
	ecute and Ftran	Examiner	Cause (Disease or litigury that initiated events resulting in death) Last Due to (or as a consequence of):					
38760,	icate be executad physician and s the burial-transit	a E						
687		edicai	d					
Box	death certifica attending ph		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	ery
m.	death e atte	Physician/M	in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de lad by the detached t	hys	9 ☐ Unknown					
	res tha ignad be de	by F	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause give	n in Part I.		cco use contribute to t	
ord	w require baen si	ted				1 🗆 Yes	2 No 3 Prol	bably 4 Onknown
Records,	S C/	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E	: The					performe 1 ☐ Yes 2 8	ed? death? No 1 □ Yes	2 🗆 No
<u>=====================================</u>	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death (
o	Phys r this sral di	-	1 Yes 2 No No Note Indigent 2 ER/Outpatient 2. Manner of Death 28a. Date of Injury 28b. Time of	3L DOA	at Nursing Home	a 5 er esiden d. Describe how		fy)
lon	nding Phy th. : After this e funeral c	atior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	28c. Injury Work' M 1 □ Y	? ′es 2 □ No		,	
Division of Vital	l or Attence after death Director:	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28		et and Number or Run	al Route Number,
Ō	tel or A rs after al Dire ed in by	Certification;	building, etc. (Specify)			City or Town,	Sidie/	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time	e, date and place, an	d due to the cau	se(s) and manner as s	stated.
	thin 2. the I	Medicai	one) and manner stated. 29b. Signature and title of certifier	200 Linnas	number	20-	Date signed /Marst	Day Vocal
1	7 × 1 8		A. La	250. Elosiss	35012	290	Deto Les	12.2005
	Ø,		30. Name and address of per in who completed cause of death (Item 23a) (Type, Pr	Print)		6		
	10		J. Kevin Lrucot mo 2	North	Ave	. Bel	Acr, Mo	1. 21014.
	Sta	te	31. Date filed (Month, Day, Year) 32 Negistrar's Signature	- M			•	· · · · · · · · · · · · · · · · · · ·
1	Registr	ar	2 Medical Examiner: On the basis of examination and/or inversional and manner stated. 29b. Signature and title of certifier 30. Name and address of per in who completed cause of death (Item 23a) (Type, Proceedings) 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 1 4 2005	NEW .				

State of Maryland / Department of Health and Mental Hygiens 33334 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Oct. 13, 2005 **Physician** Carmen Ines Rivera-Cuesta 9:00a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Manor Care Baltimore 8. Date of Birth

July 16, 1930

9. Birthplace (State or Fo 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 TF 75 328-32-1077 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, I've Medical Evanirar must be notified at Baltimore Pikesville Md. 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 39 Austringer Ct. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 Yes 2□No Specify: Puerto Rican Maryland 21215-0036 White þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item Market in the Mental Item Mental Item Item. Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Psychiatrist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julio Rivera Ana Maria Estrada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pilar Cuesta - Daughter 39 Austringer Ct., Pikesville, Md. 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Oct. 17, 2005 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al envice I 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jementia years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No 2 Accident investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Oct, 13, 2005 (no) 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 North Charles ST, Suite 203, Touson MD 21204 Black 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4 2005

		1 - For Amend Item44 Registrar 1. Decedent's Name (First, Middle, L	ast)				-	2. D	ate of Death	Day Year	3. Time of Dear
Physici /Medio		Alora	Ann Robert	son				1 -		1, 2005	10:14 F
Examir	-	4a. Facility Name (If not institution, g		-)			Location of D	eath	4	4c. County of De	
		Carroll Hospital 5. Social Security Number 6.		ge (In yrs. last birt		stmins nder 1 Year	ter If Under 24	Hrs. R n	ate of Birth	Carrol	1 rthplace (State or For
Funeral Director		217-86-9512	1□M 21/2F	1 -	Yrs. Mont			Min. Ma	<i>ionth. Dav. Yea</i>	962 Max	ryland
Jii Cotoi		Usual Residence of Decedent							,		
whow	Ļ	10a. State 10b. County		10c. City, Town							10d. Inside City Lir 1 ☐ Yes 2 🛣
- Ba-1	Director	Md. Baltim	ore	opp	erco	Zin Codo			107 (Citizen of What C	
a or 2		10e. Street and Number 14525 Hano	ver Pike		101.	Zip Code	155		Tog. (U.S.A.	ountry?
78 23 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	era	11. Marital Status	12. Was Deceden		13. Was De		spanic Origin n, Mexican, P	? (Specify Y	es or No-	14. Race - Am	
Framiner	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 K If Yes, Give Year or Dates	No		s 2 No	Specify:	чепо нісал	i, etc.)	Black, Wh	
natu	etec	15. Decedent's (Specify only highest g		16a.	Decedent's U	work done o	uring most of	working	16b.	Kind of Busines	s/Industry
hen.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	'iite. DO NO Housew)		Н	omemake	r
Depertment of Health and Mental Hygiene. Important: if items 23s or 28s-f show important: if item 27 is marked other then "naturel; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	To Be Co	17. Father's Name (First, Middle, Last) Thomas Daniel Wilson 18. Mother's Name (First, Middle, Maiden Sumants Sandra Ann DeVess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sandra Ann DeVess)									
Ith and M 27 ie mar r trsumat		,				•					
ent of Hea ht: if itam ny or othe		Randall Robertson - Husband 14525 Hanover Pike, Upperco, Md. 21. 20a. Method of Disposition Quality Community									
Depertm Importar eny injur		21. Signature of Funeral Service Lie		_	22 Name Eck 116	and Address hardt U5 kei	s of Facility Funera sterst	l Cha	pel, P.	A. ngs Mill	21117
hysicien and he burial-transit	ai Examiner	Sequentially list conditions, the state of t	c.	s a consequence of							
physic the b	dicai	•	d.								
y the ettending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2	3 □Ectopi 5 □ Other	c pregnancy (specify)				23d. Date of de Month	elivery Day Year
been signed by the e should be detached f	6	Part II. Dther significant conditions	contributing to death	but not resulting in	the underlyin	ng cause give	en in Part I.	_	23e. Did tobacci 1 ☐ Yes	_	to the cause of deatl Probably 4 🛣 Unkr
ete has page 2	Completed							-	4a. Was an autopsy performed? XYes 2□N	prior to death?	utopsy findings ava completion of cause s 2 No
nis certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	c		eck only one)		
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within 24 hours efter death. To the Funerel Director: A completely filled in by the fu			Scene Physician: To the bes					Upp lace, and de	perco, l	(s) and manner a	is stated.
he Fu	Medicai	(Check only 2 X Medical Ex	aminer: On the basis and manners		d/or investiga	tion, in my op	oinion, death o	occurred at			
To t	Σ	29b. Signature and title of certifier 29c. License number OCIME								ober 12,	
		Harran I MA	o completed cause of						12		Iand 2120

			1 For State Registrar	State of Maryla	and / Depa	artment of H	ealth an Death		giene ()	05	33336
٩	Physici	an	Decedent's Name (First, Middle, Lateral	,				2. Date of De Month	path Day	Year	3. Time of Death
	/Medi Examir	cal	Helen L. S 4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of [Octuber Death	4c. County	of Death	3130 M
	- Funeral Director	**	213-20-9139	HOSPITUI ex 7. Age (In y. □M 2XIF 79	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. Feb. 2	th iy, Year) 1926		ce (State or Foreign Land
	ehow	ž	Usual Residence of Decedent 10a. State 10b. County MD Balti		City, Town or Lo	cation Baltimor	0			100	d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-f	rect	10e. Street and Number	more		10f. Zip Code			10g. Citizen of V	What Countr	
	23a o	al D	5100 Arbutus Ave	nue		21:	227		United	States	S
980	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow ha Mudical Examiner must be rotified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 X No	spanic Origin , Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rac Blac Specify	e - Americar ck, White, et /: W]	n Indian, c. nite
21215-0036	filed within 72 ho Hygiene. ther then "natur int, ine Madies	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired) ales Cleri	uring most of	working	16b. Kind of Bu	usiness/Indu	
Maryland 2	S E S	To Be Co	17. Father's Name (First, Middle, Last) Andrew Haag				18. Mother's	Name (First, Middle,			
lary	and and s m	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street a	nd Number o	r Rural Route Numbe	er, City or Town,	State, Zip C	'ode)
	1 end 2 Health tem 27		Daniel B. Spalt, 20a. Method of Disposition		903 I		ck Rd.	, Bel Air,			
nor	Pages nent of I int: If Its iry or o		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State 🗼 M		Memoriat			20c. Location -		
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott	(21. Sinnature of Funeral Service Licen		1A 8 22	. Name and Address	of FacilityA	-15-2005 mbrose Fur ing Rd., A	Parkvil neral Hos	me, Ir	
# ***	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.						A Ir	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons		1)6001			EXAMINER		11000
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):			NEO BY	MEDICAL MD		
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cons	equence of):		723	Dunilly 12 2 24	V III		
Box 6	death certifica e attending ph ed for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3	Ectopic pregnancy	Ckr.	James	23d. Date Mor	e of delivery	
P.O.	t the c by the tached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)					,
	w requires that been signed should be de	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the ur	iderlying cause giver	n in Part I.	23e. Did to	obacco use contr ′es 2□No		cause of death?
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Vita	Physician: Th this certificete al director, pag) Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No	Hospital:		Other		Death Check only or			
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Division	 Hospitel or Attending 24 hours efter death. Funsral Director: A letely filled in by the function 	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of Contr	home, farm, stre city)	Hospital		28f. Location (S City or Tow 900 Carl	itreet and Numbern, State)	er or Aural A	timese MD
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	To To con	Σ	29b. Signature and title of certifier	NIC 011	0	29c. License	number	1.	29d. Date signed	(Month, Da	y, Year)
7	10		30. Name and address of person who of	completed cause of death /It	om 23a) (Type 5	pat DO	036.	165	10[12	- 05	
	У		St. Agnes Ho	spital - 9	00 Ca		enve	· Baiti	more	MD	21229
	Sta Registr		31. Date filed (Mohth, Car Year) 4	2005 32. Registrar's Sig	nature /	beele)		

Spalt, Helen L.

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2 = JEL 1	1/4	Decedent's Name (First, Middle, I							2. Date of De	ath		3. Time of Death	
Physic		Selene Swazest	Stokes						Octobe	r 7	2005	6:49 AM M	
/Medi		4a. Facility Name (If not institution,				4b. City, Town	or Locatio	n of Death	OCCODE		ounty of Deat		
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Cunaval			. Sex		yrs. last birthda	() If Under 1 Yea		ler 24 Hrs.	8. Date of Bi	th	9. Birt	hplace (State or Foreign	
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Ma-1-	ctor	D.C.			wa	shington						1X1 Yes 2 □ No	
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iled within 72 hours after death with the Maryland Hygiene. Hygiene. Ither then "netural", or items 23e or 28e-1 show only the Medical Examinat must be notified at	Funeral Director	5964 Southern A	Avenue, S	S.E		2	0019			U.	S.A.		
dea	ner	11. Marital Status	12. Was Dec Armed F	edent Ever	in U.S. 13	I. Was Decedent of If Yes, specify Co	f Hispanic (uban, Mexic	Origin? (Specan, Puerto	ecify Yes or Ne Rican, etc.)	o- 14	 Race - Ame Black, Whit 		
or It	F	1 ☐ Never Married 2 ☐ Married		2 💢 No		1 □ Yes 2X N					pecify: B1	ack	
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o = 15	20a. Method of Disposition 1 Burial 2 Commentary or other place) 4 Donation 5 Dother (Specify) Chesapeake Crematory 10-1									Beltsville, Maryland			
Pa Imen Itant: jury		4 □Donation 5 □ Other (Spe				22. Name and Add							
permit. Pages 1 Department of H Important: If Ite eny Injury or ot		21. Signature of Funeral Service Li	ensee Bac	on C	10361							C. 20010	
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the	death. Do not e	inter the mode of o	tying, such	as cardiac o	or respiratory a	arrest,		Approximate Interval Between	
Physician	V.	Immediate Cause (Final	•		injuries	,						Onset and Death	
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S 2	OB	examiner? 1 XYes 2 No	Hospital: 1	Inpatient	2 ER/Outpat	ient 3 DOA	Other: 4 🗆	Nursing Ho	me 5 Res	idence ex	Other (Spe	ecity) Scene	
	E	27. Manner of Death	28a. Dat	e of Injury onth, Day Ye	28b. Time	of 28c. I	njury at Work?		28d. Describe	how injury	occurred		
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DIVISIO	ertification:	3 Suicide 6 Could no	289. Pla	ce of Injury ding, etc. (5	- At home, farm,	street, factory, offi	сө		28f. Location	(Street and	Number or R	ural Route Number,	
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2 E S	ai	29a. Certifier 1 ☐ Certifying				eath occurred at the							
ne Hos ne Fun eletely	edicai	(Check only 2 🔼 Medical E		inner stated		investigation, in π	y opinion,	death occur	red at the time	, date and p	lace, and du	e to the cause(s)	
To the Ho within 24 To the Fu completel	Σ	29b. Signature and title of certifier				29c. Lic	ense numb	per		29d. Date	signed (Mon	th, Day, Year)	
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1 1 and		30. Name and address of person v	vho completed ca	use of deat	h (Item 23a) (Tyl		Lili					_× 2	
2 ac pard		Tasha Z Gre	enher.	1 Mi	D.	111 Penn	Stre	et Ba	altimor	e. Ma	ryland	21201	
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Regis	trar	OCT 1 4	2005	A RELIEF	J. St. 1	doorle							

			1 - For State Registrar	State of M	arylar	nd / Depa <i>Ce</i>	artme <i>rtifica</i>	nt of He te of D	ealth a Death	and M	ental H	ygiene Reg. No	200	05	33338
	Physici /Medic	cal	Decedent's Name (First, Middle, Larry Sparks Aa. Facility Name (If not institution, general section).				4b Cit	y, Town, or	Location		2. Date of D Month Septem	ber.		Year 005	3. Time of Death
	Examir Funeral	ner	Johns Hopkins Bay	Sex Medica	al Ce	last birthday)	Ba	Hrno;	4	24 Hrs. Min.	8. Date of B	irth	boutton	10 re	City ace (State or Foreign h Carolina
puolina	Director Moys J	or	Usual Residence of Decedent 10a. State 10b. County	imore	10c. Ci	ty, Town or Lo		n			May 13	5; [9]	63		od. Inside City Limits
di di	ms 23a or 28a-f show	al Director	10e. Street and Number 8816 Gilly Way					ip Code 21133	3			_	tizen of Wh	nat Count	ry?
	II', or items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	100			edent of His ecify Cubar 2 No	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or N Rican, etc.)	lo-	14. Race Black Specify:	White, e	
10 Z 1 Z 1 3-0036	Hygi ther int, I	Se Completed	15. Decedent's (Specify only highest statementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, La	12 Father's Name (First, Middle, Last) amuel Sparks, Jr.						t of workir	g (First, Middl	Н		care	Facility
Maryland Sebould to (6)	and Mental	To B					-	ss (Street a	nd Numbe	or Aura	arion Route Number	ber, City o	or Town, S	tate, Zip (Code)
Saltimore, n	Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1 Murial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State		Place of Disponentery, crei	sition (N	ame of other place)		ate	20c. L	ocation - C	ity or Tow	
	hysician and burial-transit the private transit transi	dical Examiner	23a. Part1. Enter the disease, in co shock, wheart failure. List on Immediate Cau e (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Brzzin i Due to (or as b. Due to (or as c. Due to (or as d.	Hern a conseq	uence of):		ade or dying	, such as	cardiac of	respiratory	arrest,			Approximate interval Between Onset and Death
De death cediff	been signed by the attending p should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3□	Ectopic Other (pregnancy specify)					23d. Date Monti	,	y Day Year
Or Vital necords, P.O. BOX of	s been signed b	Completed by Pt	Part II. Other significant conditions To Koplusynosis HIV / AIDS	contributing to death b	ut not res	ulting in the u	nderlying	cause giver	n in Part I.			Yes 2	24b. We	Probal	bly 4 Unknown
VICION The L	s certificate has b	0	25. Was case referred to medical						26. Place	of Death	1 2 Yes	ormed? 2□ No	de	or to compath? Yes 2	pletion of cause of
Attending Physic	fte a	ation: To B	examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigat	1	ry	ER/Outpatier 28b. Time of Injury		28c. Injury	4 LI NU	2	e 5 Res 8d. Describe				
SIVIC SIPLOS ATT	within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Certification:	3 Suicide 6 Could not determine	building, et	c. (Specif	y) 					City or To	wn, State)		Route Number,
To the Hospital or	thin 24 ho the Fune mpletely f	Medical	29a. Certifier (Check only one) 1 ✓ Certifying I 2 ☐ Medical Ex 29b. Signature and title of certifier	Physician: To the best aminer: On the basis of and manner sta	f examina ated.	tion and/or in	estigatio	n, in my opi	nion, deat	h occurre	d at the time	, date and	place, an	d due to t	he cause(s)
1	358		Coser	M.D.	lo ath (lt.)	- 00-) T	Brief)	534	++++	1		Sept	embe	V 25	7, 2005
2	Sta Registr		31. Date filed (Month, Day, Year)	CLOCK Ch	ar's Signa	123a) (Type, 414)	Print) Ea	Hern	Aver	nue,	Baltin	none,	Mari	plan	121224

			For State Registrar	State of M	laryland / D	epartmen			and Me		/ 131	05	33339
			Decedent's Name (First, Middle, I	Last)				Journ	2	. Date of Deat			3. Time of Death
	Physici /Medio		Franklin E	mil Scl	hmidt					Month Dctobe	Day 8	Year 2005	10: 45PM
	Examir		4a. Facility Name (If not institution, g	ive street and number,)	4b. City,	Town, or	Location o	of Death	Delanc	-	ty of Death	
			Baltimore VA					nore				NIA	
	Funeral		,	. Sex 7. As 1 1 M 2 ☐ F	ge (In yrs. last birth	day) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		218-38-4407 Usual Residence of Decedent	n –	63	5.			(05/11/1	942	Mar	ryland
	laryland show		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Mar e-f sl	ctor	MD Balt:	imore	Kings	ville							1 ☐ Yes 2X No
	ath with the Maryla s 23a or 28e-f shov	Funeral Director	10e. Street and Number			10f. Zip	Code			10	0g. Citizen of	What Cou	ntry?
	ath w	rail	12123 Stoney B				1087				U.S.A	•	
	ter dea Itams	une	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		ice - Ameri ack, White,	can Indian, etc.
36	a o E	by F	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 ☐ If Yes, Give Y Year or Dates:	ietnam	1 ☐ Yes 2	No.	Specify:			Speci	ity: Wh	ite
21215-0036	72 hours "naturel",	ted	15. Decedent's	Education	16a. C	ecedent's Usua	I Occupa	ition			16b. Kind of I		
215	be filed within 72 ho ital Hygiene. id other then "natu event, Ira Nic III	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or		Give kind of wor ife. DO NOT us			of working				,
	filed with Hygiene. other ther	Con	9			Disable	E				N/A		
and	be fill htal H od ott	Be	17. Father's Name (First, Middle, La	*				18. Mother	r's Name (F	First, Middle, N	faiden Suma	me)	
Maryland	d 2 should be filed withir th and Mental Hygiene. 7 is marked other then traumatic event, I.e. M.	L C	Emil Ferdinand S 19a. Informant's Name/Relationship		10h h	4-11: 4-1	(0)			Anna Sr			
Ma	h ar 7 is 7 rau	- 4				Mailing Address							
ē,	1 a Hear		Rosalee A. Beva 20a. Method of Disposition		20b. Place of D	11 Nelso Disposition (Name crematory or ot	on M.	TIT K	oad – Date		Oc. Location		
E	0 0		1 X Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec			r Memori			10/12	/2005	Dol A	. M.	bac luwa
Baltimore,	permit. Pag Department Importent: b eny injury o	1	21. Signature of Funeral Service Lic		Der Ai	22. Name and	Addres	s of Facility	E. F	. Lassa	hn Fur	neral	Home, P.A.
Ö	P		PES S	assaln		11750 I							
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each l	d the death. Do no ine.	t enter the mode	of dying	, such as c	cardiac or re	espiratory arre	st,		Approximate Interval Between
	Physician	i n	Immediate Cause (Final disease or condition	a Squ	amous (cell ca	rair	ายเทล	of th	e tongu	*		Onset and Death
	/Medical Examiner		resulting in death)		a consequence of								
		je l	Sequentially list conditions,	b. Due to (or as	a consequence of)							_	
K	rted 1 Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	3 5 6 (5. 25	a 001100qu01100 01)								
٦,	execu In and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:						-	
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dicai		d									
9	ntifica ng ph a as th	0	IF FEMALE:										
Вох	death certifica attending ph d for use as t	an/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pre	gnancy					ate of delive	,
0.	t the de by the a tached f	Physicia	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 Other (spe	cify)				IVI	onth	Day Year
Δ.	that the	Ph	Part II. Other significant conditions	contributing to death b	out not resulting in th	ne underlying ca	use dive	n in Part I		23e. Did toba	acco usa con	tribute to th	ne cause of death?
Vital Records,	uires sign ld be	d by	_	Ü	•	,,	3				2 □ No	3 ☐ Prob	
00	w require been sign should t	ompieted								24a. Was an		Were auto	psy findings available
Re	The law ate has b page 2 sl	mo							_	autopsy perform	ed?	prior to cor death?	mpletion of cause of
ital	(0 1	Se C	25. Was case referred to medical					26. Place of	of Death (C	1 ☐ Yes 2	-	1 🗆 Yes	21XNo
of V	di is	To B	examiner? 1 🗆 Yes 2 🚉 No	Hospital:	ent 2 ER/Outpa	atient 3 DO	Other	~		5 Resider		ner (Specify	y)
ם ם	ing Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Yea <i>r)</i> 28b. Tim		c. Injury Work	at	7	. Describe hov			
Sio	Attending r death. actor: After by the fune	icati	2 Accident investigate 3 Suicide 6 Could not	he		М		es 2□N	-				
Division	after of Dirac	Certification;	4 Homicide determine	d 286. Place of Inj building, et	ury - At home, farm c. <i>(Specify)</i>	, street, factory,	office		28t.	City or Town,	et and Numl State)	per or Rura	I Route Number,
_	e Hospitel 24 hours a e Funerel I		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge	leath occurred a	t the time	a, date and	place and	due to the co-	Isa(s) and m	anner de c	ated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Diractor: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exa	miner: On the basis o and manner st	t examination and/o	or investigation, i	n my opi	nion, death	occurred a	at the time, dat	e and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License	number		29	d. Date signe	d (Month, I	Day, Year)
•			1 to El	- 2 NO		A	1417	64351	41586	9 0	ctobe	r 8,21	005
	141		30. Name and address of person who	completed cause of d	leath (Item 23a) (Ty	pe, Print)							
	71		Stacy Kennedy	MO 10 N	ar's Signature	e St., 1	3 a 1+	Imor	e,MD	21201			
	Sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 1 4 200	5 Seems	ai s Simpature	exce							

State of Maryland / Department of Health and Mental Hygien

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								Cen	ificate	of i	Death)		Reg. No.	0 0	•		
	Dhysia		1. Decedent's Nar	me (First, Middle, I	ast)				/ .		1.1	/	2. Date of D				3. Time o	f Death
	Physic /Med		()	410N	^)4	mes	~	SW.	A	MN		Septem	ber 22		Year 005	9:5	5 A.M
	Exami		4e. Fecility Name	(If not institution, g	ive street end n	umber)		-		4	4b. City, To		ocation of Dea		County of			
			2755 Po	sevtown	Road						Nanj	emov			Cha	rles		
	Funeral		5. Social Security	Number 6.	Sex	7. Age (In yrs. last birt	hday)	If Under 1	Year Days	If Under Hours		8. Date of B	irth		9. Birthpla	ice (State	or Foreign
	Director		214-30-2		1 ⊊ M 2□ F			rs.	TOTAL OF THE PARTY	Duyo	Tiodis		Mar. 2		35	Md	y)	
	pus *		Usual Residence	of Decedent 10b. County		T 1	0c. City, Town	or Loo	ation							1		
	/anyla	5	Md	Char	100		oo. Oily, Town	OI LOCA	Nanje	mai	17					10	d. Inside C	2 □ No
	28a-	ec ec	10e. Street end Nu								у							20140
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Modical Examiner must be notified at	Funeral Director		eytown R	oad				10f. Zip Ci	oae 0662	2			10g. Citize Unit		at Countr State		
	ems	ne.	11. Marital Status		12. Was Dec	cedent Eve	er in U,S.	13. W	as Deceden	nt of Hi	ispanic Or	igin? (Spe	ecify Yes or N Rican, etc.)	lo- 14		America		
20	or it	by FL	_	ried 2 Married		2 No			Yes 2	-	Specify:		riicari, etc.)			White, et		
21215-0020	ural'	D D	3 ☐ Widowed		Year or I	Dates:									ъресну.	B1a	CK.	
15	"nat	Completed	(Spe	15. Decedent's I cify only highest g	Education rade completed,)	16e.	Decede (Give ki	nt's Usuel C nd of work of NOT use i	one d	ation during mos	t of worki	ing	16b. Kind	d of Busi	ness/Indu	stry	
12	should be filed within the Mental Hygiene. marked other then imatic event, the Mental	Ĕ	Elementary/Sec	, , ,	College	(1-4or 5+)												
6.4	Per t		10th 17. Father's Name		t)		S	upp]	Ly Sup	erv			/Eimt Middle	Feder			ment	
an	od be	Be C											(First, Middle		umame)			
7	d 2 should be fi th and Mental H 7 ie marked ot traumatic ever	2	Norman	SWANN ame/Relationship	(Type Brint)		106	A 4 = ilia =	A				Carro					
Maryland	har rie			wann / W	,								i Route Numl			ate, Zip C	Code)	
	1 ar Hea Hea Hea		20a. Method of Dis		116		20b. Place of				ı Ku.	Nan	Date				- 0	
Baltimore,	0 0		1. Burial 2	☐ Cremation 3 !	☐Removal from	State	cemetery	, crema	tory or othe	r place		1		20c. Loca				
뜶	# 돌 등 등		4 .	5 Other (Spec		M	t. Hop	-	_									
Ba	Deparament of the policy of th		21. Signature of	neral Service Lio	See D		Unn		Name and A				Capito				nc.	
			W	alon 1	MAN	かんし	Belle	4		-			NE Was	-	OC 20	0002		
			23a. Parvi. Enter t shock, or hea	he disease, or our distant	plications that of one cause on o	caused the	death. Do n	enter	the mode o	f dying	g, such as	cardiac o	r respiratory a	arrest,		A	pproximat	e ween
	Physician			U	Λ.	950		0		1	-					Č	nset and I	Death
1	/Medical Examiner		Immediate Cause disease or condition resulting in deeth)	(Final on	, √\\ \	1000	roll		(w	1a	IA	010	1					
		<u>.</u>	resulting in deetin)			Due	to (or as a co	nseque	ence of): (
_	sit ed	Examiner			p If	1 105	Jen											
6	eecut and I-tren	хац	Sequentially list co	nditions,	n	Due	to or as a co	nseque	nce of):									
60,	be e) cian burie		Sequentially list co if eny, leading to in cause. Enter Under Cause Disease or	erlying I	. Ke	2015	VG	1	1.)								
87	cete ohysi the	di Gi	that initiated events resulting in death)			Due	to (or as a co	nseque	nce of):									
ox 68760,	n certificete be executed anding physician and use as the buriel-trensit	ın/Medicai		L	ď													
Bo		lä																
Ö	v requires that the death been signed by the etter should be detached for u	Physicia	Part II. Other signif	icant conditions	contributing to de	eath but no	ot resulting in t	he unde	erlying caus	e give	n in Part I.		23b. Did	tobacco us	e contri	bute to ti	ne cause d	of deeth?
P.O.	hat the od by detac		1,	\10	7	MA	Met	e	-				1 🗆	Yes 2	No 3	☐ Probal	oty 4 🗆	Unknown
Division of Vital Records,	res t signe	9	- /	1 court		104	ALD!		4			-						
Ö	requi	Completed											24a. Was	an autopsy ormed?	, 2	availa	autopsy f able prior t	0
Şe.	N S S	ğ		V/A												of de	eletion of c ath?	ause
=	The la	ပ္ပ											1 🗆	Yes 2K	No	1 🗆 ነ	′es 2□	No
/ita	ilcien: The certificate rector, pag	Be	25. Was case refer examiner?	red to medical							26. Place	of Death	(Check only	one)				
\leq	hysic his cr	ဥ	1 ☐ Yes 2 🔼		Hospital: 1 □ I	Inpatient	2 ER/Outp	atient	3□ DOA	Other	r: 4 □ Nui	sing Hom	ne 5ĂResi	dence 6	Other (Specify)		
ב	ng Pl	Ë	27. Menner of Death	h 5 ☐ Pending	28a. Date	of Injury th, Dey Ye	ar) 28b. Tin		28c.	Injury Work	at ?	2	8d. Describe	how injury o	occurred			
<u>0</u>	ath. or: Ai	atle	2 Accident	investigatio	n		,	,			es 2 🗆 N	No						
ž	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury -	At home, farm	, street	, factory, off	fice		2	8f. Location (Street end N	Vumber (or Rural F	oute Num	ber,
	talo rs af ral Di fed ir					, (=,							- ing - i - i - i	, 5.2.07				
	To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only	1 Certifying Pt 2 ☐ Medical Exam	ysicien: To the	best of my	knowledge, o	leath oc	curred at th	e time	, date and	place, ar	nd due to the	cause(s) an	d mann	er as state	ed.	\
,	the F	8			and man	ner stated.		N 111V65	ilgation, iii r	пу орг	mon, deal	n occurre	u at the time,	date end pia	ace, and	due to tr	e cause(s	'
1	5 <u>x</u> 5 0 0	Σ	29b. Signature and	title of certifier					29c. Lic	ense	number	1-1	_	29d. Date s	signed (A	Month, Da	Year)	
	1		>	0					V	13	570	5 5		01.5	3.	05		
	5		30. Name and address	ess of person wno	completed caus	e of death	(Item 23a) (Ty	/pe, Prir	nt)									
			wood	WH	Fac	du	MI)	6620	Cr	ain l	Hwy.	Suite	101 L	a Pi	lata,	Md	20646
	Sta		31. Date filed (Mont	h, Ray Year) 4	2005 32. R	e sistrar's S	Signature	1	adi		-					•		
	Registr	ar		OOIT	2000	A COLUMN	75	19										

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artme <i>tifica</i>	nt of H te of L	ealth a Death	and M	ental H	ygiene Reg. No	2005	3334	1
			1. Decedent's Name (First, Middle, Last)							2. Date of I	eath Da	v Year	3. Time of Death	
	Physicia /Medic		Marianne A. Solom	non								ó, 2005		М
1	Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City	, Town, or	Location o	of Death		4c	. County of De	ath	
			6301 Contention C	ourt			hesda				Mo	ontgome	ry	
	Funeral Director		220-56-3783	7. Age (In yrs. 57	last birthday) Yrs.	If Und Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Year)	947 Nev	inthplace (State or Forei Sountry) V York	gn
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limit	ts
	aryle sho	5											1 □Yes 2XN	10
	28a-1	Director	Maryland Montgomer 10e. Street and Number	у ве	thesda	10f Z	ip Code				10a. Cit	tizen of What 0	Country?	
	with with	2	6301 Contention C	· · · · · · ·			0817						•	
	ns 23	era		2. Was Decedent Ever in U	.S. 13. \			spanic Orig	igin? (Spe	cify Yes or I			nerican Indian,	
36	ss I and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. The Health and Mental Hygiene. The West Tismarked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at	by Funeral	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 □Yes 2 X No If Yes, Give Year or Dates:			ecify Cuba 2 ∑ No	n, Mexican Specify:	n, Puerto F	Rican, etc.)		Black, Wh		
Maryland 21215-0036	hour tural	ba b	15. Decedent's Educ		16a. Dece	ient's Us	ual Occupa	ation			16b. K	ind of Busines	hite s/Industry	
ή	n 72	Completed	(Specify only highest grade	completed)	(Give	kind of w	ork done d	during most	t of workin	9	100.11		a moosty	
7	with ene. then	E I	Elementary/Secondary (0-12)	College (1-4or 5+) 4		nema					0	wn Home	2	
9	Hygi Hygi ent,		17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Midd				
au	d be do do do do do do do do do do do do do	To Be	Cornel Holder					Vi	ctor	ia Pil	ea			
<u> </u>	mari mati	F	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Addre	ss (Street a					or Town, State,	Zip Code)	
Š	od 2 lith a 27 is r trau		John R. Solomon/Hu	ısband	6301	Con	tenti	on Co	urt,	Bethe	sda,	Maryla	and 20817	
Baltimore,	r Heal		20a. Method of Disposition	1 .	Place of Dispo	sition (N	ame of			er 13,		ocation - City o		
5	Peges nent of I int: if it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1 Sou1s	s Cer	neter	v 2	2005		Ger	mantowr	, Maryland	
			21. Significant Fund rat Service License		22	. Name	and Addres	s of Facilit	y Robe	ert_A.	Pum	phrey F	Tuneral Homeonsin Aven	e/
ä	permit. Departr Imports eny inju		1 Spine	M00	803 B	etne:	sda-U	nevy Maryl	and	20814	-350	57 Wisc 1	onsin Aven	ue
			23a. Part1. Enter the disease, or complic	cations that caused the deal	h. Do not ent	er the mo	ode of dying	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between	
	Nevoleion		shock, or heart failure. List only on Immediate Cause (Final		Crra + on	. A +-							Onset and Death	
> '	hysician /Medical		disease or condition resulting in death)	Multiple Due to (or as a consec		n At	ropny						15 Years	
	Examiner			500 10 (0. 00 0 00	,									
	*	ē	Sequentially list conditions, if any, leading to immediate	Dua to (or as a consec	uunea of):									
6	oted d ansit	Examiner	if any, leading to innihediate cause. Enter Underlying Cause (Disease or irijury that initiated events											
<u> </u>	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consec	(uence of):									
8760,-	icate be executed physicien and s the buriat-transit	dical	d											
68	tifical ng phi as th	led									- 1			
Вох	h cer endin	5	23b. was decedent pregnant	3c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Tectopic	pregnancy					23d. Date of d		
ω.	that the death centitied by the ettending to detached for use as	icia	in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregnant at time of o		Other (.	Month	Day Year	
ö	it the by th tache	hys	9 Unknown	9CJ OHKNOWN			_							
Division of Vital Records, P.O.	8 5 9 B	d by Physician/Me	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause give	en in Part I.		1			to the cause of death? Probably 4 Unknow	vn
ò	w requir been si shauld	ete								24a. Wt	ıs an	24b, Were	autopsy findings availab	ole
Re	ne ian e hes ge 2	Completed		,						pe	opsy formed?	prior to death?	completion of cause of	f
a	n: Ti ficete or, pa	မ C	25. Was case referred to medical				-	OC Diago	of Dooth	(Check only		1 1 Ye	es 2□No	
≓	Physician: rthis certifice ral director, i	00		ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 🛭	Othe Othe	00				6 □Other (Sp	nacifu)	
ō	Phy rthis raid	5	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury Work			8d. Describ			ocny)	
O	ding h. Afte fune	ţ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		<br Yes 2 🔲	No					
is is	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, facto	ory, office		2		(Street ar		Rural Route Number,	
	urs al urs al praf D		One Continue A Continue	Jefens To the Free Co.	audodes de l'	. 057:	d at the state		d nia a	nd due to "	0.000=1	\ and masses	os stated	-
	Hospital 24 hours a Funeral I tely filled	Medical		ician: To the best of my knower: On the basis of examination and manner stated.										
	To the Hospital within 24 hours a To the Funeral Completely filled	Mec	29b. Signature and title of certifier	and mainer stated.		2	9c. License	e number			29d. Da	te signed (Mor	nth, Day, Year)	
	E ₹ 8		Moul					727	2)		_		1 0005	
	, 1			malatad agus af 4 on 20	- 22c) T								1, 2005	
	10		30. Name and address of person who con									-		
	- C+		Stephen G. Reich, 31. Date filed (Month, Day, Year)	M.D. 10 Sout		W St	reet,	N4W	40, E	altim	ore,	maryla	na 21201	
	Sta Registi		OCT 1 4 21		La .	bed	2							

State of Maryland / Department of Health and Mental Hydien 2005

				1 - For State Registrar	State of	Marylar	nd / Depa	artment of rtificate of	Health and N		gien 2 () (05	33342
ě	1	Physici	an	Decedent's Name (First, Middle, Last	Willia	am W.	Schor	mburg, S	r.	2. Dale of De. Month	Day	Year	3. Time of Death
the but		/Medio Examir		4a. Facility Name (If not institution, give Gilchrist Center				4b. City, Town	or Location of Death	Octobe	4c. Count	y of Death	4:50 P "
)-		Funeral		5. Social Security Number 6. Se	x 7 gM 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birt (Month, Da	th y, Year)		place (State or Foreign intry)
5	5	Director		222-14-4118 Usual Residence of Decedent		78.				Dec. 4	,1926	Del	aware
0.8.		death with the Maryland me 23a or 28a-f ehow rinkal termilled at	Director		imore	10c. Ci	ty, Town or Lo	ocation	Rosedale				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Ò		with th		10e. Street and Number 9812 Whitney Dr.	ive Ap	t. 326		10f. Zip Code	21237		10g. Citizen of United		,
ž	980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-1 ehov eny Injury or other traumatic event, the Medical Exant car must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 🖫 Yes : If Yes, Give Year or Da	ces? 2 🗌 No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specii	ck, White	ican Indian, , etc. hite
William	21215-0036	ithin 72 he he. han "natu hedical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-	4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of work	ing	16b. Kind of E	Business/li	ndustry
	d 21	filed w Hygier other th	Cor	17. Father's Name (First, Middle, Last)	4 Years		Eng	gineer	18. Mother's Nam	e (First, Middle,			ndustry
Ex-	Maryland	Mental Mental arked c	To Be	William Schombu	rg				Fanny	Haeffne	r		
3	Man	d 2 sho h and f 7 ie ma trauma		19a. Informant's Name/Relationship (T		\			etand Numberor Run nerals Hwy				,
Schomburg,	Baltimore,	ages 1 and ant of Heali it: If Item 2 y or other		Beth S. Wojton (D. 20a. Method of Disposition 1 Burial 2 Cremation 3 Disposition 5 Other (Specify,	Removal from S	20b. I	Place of Dispo cemetery, crea	osition (Name of matory or other p		Date	20c. Location	- City or T	own, State
\sim	Baltir	permit. P Departme Importer eny Injur		21. Sign ture of Funeral Service Licens		ull) 22 I	2. Name and Add		Home of	Dundal	.k, I	-
•	d told	Physician /Medical Examiner		23a Part1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aW	used the deal ach line. C + A or as a consec	ih. Do not eni	ter the mode of d		or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec							
	.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		nth 2 ☐ Feta antattime of c	al déath 3	Ectopic pregnar Other (specify)	ісу			ale of delive	very Day Year
	rds, P	iw requires that s been signed t should be deta	ed by P	Part II. Other significant conditions co	ntributing to dea	alh but not res	sulting in the u	nderlying cause (given in Part I.	23e. Did to	_		the cause of death?
	al Reco	i: The faw re icete has be- r, page 2 sho	Completed							24a. Was aulop perio 1 \(\text{Yes}	rmed?	prior to co death?	opsy findings available ompletion of cause of 2 No
	Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ation: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ In 28a. Date o (Month		ER/Outpatier 28b. Time o Injury	f 28c. In		h (Check only one 5 Residue) 28d. Describe h	dence 6 🛣 Otl		m) Hospice
	Divis	tal or Atters efter de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At h g, etc. (Speci	ome, farm, st	reet, factory, offic	Э	28f. Location (S City or Tox	Street and Num vn, State)	ber or Rur	al Route Number,
		the Hospi nin 24 hou. the Funer ipletely fill	Medical	(Check only 2 Medical Exam	sician: To the liner: On the ba and mann	sis of examina	owledge, deat ation and/or in	vestigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
4		with To I	2	29b. Signature and title of certifier Anthony	Ale	· ·	ip		nse number		29d. Date signs	ed (Month,	Day, Year)
•	3	3+4		30. Name and address of person who c	6 BM	of death (Iter	m 23a) (Type,	Print) Cha	25205 les St. 1	Balto	md	2/2	201
	2	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 2	005 32.	gistrar's Signa	ature A	perte					

			1 - For State Registrar	State of Ma	aryland	d / Depa	artme <i>rtifica</i>	nt of H te of L	ealth a D <i>eath</i>	and M		giene	2005	5 3334	3
	Ob., al.,	10	1. Decedent's Name (First, Middle, Las	st)							2. Date of De	eath Day	, Vo	3. Time of Dea	ath
	Physici /Medic	- 3	Graham Bertrar								OCTOBE	R 7,	20	005 8:15 F	ji M
100	Examin	er	4a. Facility Name (If not institution, give Saint Joseph		Cent	er	4b. Cit	y, Town, or	Location o	of Death DWS 0	n	4c.	County of E	Death ltimore	
	Funeral Director		212-10-8932	ex 7. Ag M 2□F	ө (In yrs. I. 89	ast birthday) Yrs.	If Und Month:	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec.	ay, Year)		Birthplace (State or Fo	reign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City L	imits
	Maryl -f •hc	to	MD Baltimo	re	P	hoenix								1 ☐ Yes 2	
	r 28a	Director	10e. Street and Number		-		1	ip Code				10g. Citi	zen of Wha	t Country?	
	23a c	alD	3107 Sunset Lane					21	131				USA		
	te dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			Was Dec	edent of Hi ecify Cuba	spanic Orig	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	D-		American Indian, Vhite, etc.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other treumatic event, the Medical Exercial mirroral fear collined at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 ☐ 1 If Yes, Give y Year or Dates:	vo 44−'4	6	1 🗆 Yes	a√ No	Specify:				Specify:	white	
21215-0036	2 hou	ted	15. Decedent's Ed	ducation	1	16a. Deced	dent's Us	ual Occupa	ition			16b. Kii	nd of Busine	ess/Industry	
215	ithin 7 19.	Completed	(Specify only highest gra	College (1-4or 5	5+)	life.	DO NOT	use retired	furing most)	of workir	ng				
121	filed w Hygier other th	Co	17. Father's Name (First, Middle, Last)	n/a		Chief	Eng	jineer		al- Ni	(Fire \$ 8 d d d)	Ball	to. Co	ounty Scho	ols
Maryland	ould be fi Mental H arked ot atic ever	o Be	Prince Albert The								(First, Middle		,	11	
کا	should and Men s marke umatic	၉	19a. Informant's Name/Relationship (19b. Mailir	ng Addre	ss (Street a			Route Numb				
	and 2 salth a n 27 is		Alice Lemmon Tho	mas/wife			_				enix,	•		, , , , , , , , , , , , , , , , , , , ,	
ore	of He of He fittern r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. PI	ace of Dispo	sition (N	ame of		D	2/05			or Town, State	
Ě	Pages Iment of I tant: If the jury or o		4 Donation 5 Other (Specify		Mo	reland	Mei	norial	Cem	eter		Park	ville,	MD	
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other 2006.		21. Signature of Funeral Carrier Loan	Elagle		Le 1	emmo	n Fu Pad	s of Facility neral onia	Hom Rd.	ne of D)ulan	ey Va	alley, Inc. 21093	
**			23a. Part Epter the disease, or com- shock, or heart failure. List only	plications that caused	the death	. Do not ent	er the m	ode of dying	g, such as	cardiac o	r respiratory a	rrest,	,	Interval Betwee	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a RAPID	NEUF	ROLOG	IC I	ETER	RIORA	OITE	N, ET	IOLO	GY	Onset and Deat	h
1	/Medical Examiner		rosoning in death)	Due to (or as			TAICT	EDE	M CC	nee	FIND:	TNICC		7 DAYS	
10		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as			.b. 1 4 b k		21'1 WIY	(000	I LINLY.	11400		7 DHTS	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
Ó,	e exec ien ar urial-tu	Ex	resulting in death) Last	Due to (or as	a consequ	ience of):									
8760,	cate be executed physicien and the burial-transit	dical	•	d											
9	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	nev									
Вох	death atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetai	death 3	Ectopic Other (pregnancy specify)				2	23d. Date of Month	Day Year	
<u>Р</u> .	that the deatl ed by the atte detached for	hys	9 Unknown	9□ Unknown											
Vital Records, F	9 Lo	þ	Part II. Other significant conditions of HYPERTENSION	ontributing to death b	ut not resu	olting in the u	nderlying	cause give	en in Part I.			obacco u Yes 2		e to the cause of death	
၀	aw requir as been si 2 should	Completed	ARTERIOSCLEROTIC	CARDIOVAS	CULAI	R DISE	ASE				24a. Was		24b. Were	autopsy findings avai	lable
œ —		Com	CONGESTIVE HEART									psy ormed? 2 \Begin{array}{c} No	deatl	to completion of cause h? Yes 2□ No	of
/ita	ysicien: The is certificate had director, page	Be	25. Was case referred to medical examiner?							of Death	(Check only				
	Physi this o	. To	1 ☐ Yes 2 🖾 No 27. Manner of Death	Hospital: 1 X Inpatie		ER/Outpatier			4 1401		ne 5 Resi			Specify)	
Ö	ding h. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	м	28c. Injury Work	at ? ∕es 2 □ N		8d. Describe	now injury	y occurred		
Division of	Attending Physicien: or death. ector: After this certific by the funeral director.	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At ho	me, farm, str								r Rural Route Number,	
á	s efte el Dir	Cert	4 Hornicide	building, et	c. (Specify	")					City or To	wn, State))		
	To the Hospitel or Attending Ph within 24 hours etter death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best niner: On the basis o and manner sta	t examinat	wledge, death ion and/or in	n occurre vestigation	d at the timen, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the ad at the time,	cause(s) date and	and manne place, and	r as stated. due to the cause(s)	
	To the within To the comp	×	29b. Signature and title of certifier				2	9c. License	number			29d. Date	e signed (M	onth, Day, Year)	
)	1.1.		Hank	1				D 14	873			10	18/0	25	
	4X \		30. Name and address of person who	completed cause of d	leath (Item	23а) (Туре,	Print)								
	A COMPAND OF		31. Date filed (Month Day, Year) 2	NOE 32 Registr	ar's Signat	uro			RIVE	T(WOON,	MA	RYLA	VD 21204	
	Sta Registi		7 7 10 12 12	The sur	مر رم	K So	ask.	,							

			1 - For Stata Registrar	State of Maryla	and / Depa	artment of F	lealth and Death		giene 005	33344
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Dea		3. Time of Death
	/Medic		LUTHER L.	TYREE, J	R.				2,2005	7:40 a
	Examin	er	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of Dea	th
	Funeral		1229 S. CLINTON 5. Social Security Number 6. Se.		s. last birthday)	BALT . If Under 1 Year	IMORE If Under 24 Hrs		N/A	thplace (State or Foreign
	Director		219-80-5841	XM 2□F 45	Yrs.	Months Days	Hours Min.	(Month, Day	(, Year) C	ARYLAND
	pu .		Usual Residence of Decedent 10a, State 10b, County	100	City, Town or Lo	t de la constant	· · · · · · · · · · · · · · · · · · ·			
	Aaryla Fahor	ō	MD. N/A		BALTIM					10d. Inside City Limits 1X Yes 2 □ No
	the h	Director	10e. Street and Number		DALITH	10f. Zip Code			10g. Citizen of What Co	
	h with	al Di	1229 S. CLINTO	N STREET			224		U.S.A	•
	ems ?	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H		pecify Yes or No-		nican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give	j	1 ☐ Yes 2 ☐ X No		0 (1041)	C	
000	hour tural	ed b	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu	Year or Dates:	16a Doco	dent's Usual Occup	ention		W.	HITE
7	n "na	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Business	industry
21	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ahow ant, the Madical Examiner must be notified at	Completed	12	College (1-4or 5+)	LA	BORER			BALTIMOR	E CITY
p	be file	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
<u>\}</u>	should ind Men s marke umatic	J.	LUTHER L. TYRE					. VONTR		
Maryland 21215-0036	d 2		19a. Informant's Name/Relationship (T) VICTORIA BENNER	•					r, City or Town, State, .	
	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition		. Place of Dispo	sition (Name of		Date	LTO . MD . 20c. Location - City or	
Baltimore,	Pages nent of I int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ F 1 Donation 5 ☐ Other (Specify)	Removal from State		matory or other place	· I	17/05 B	ALTIMORE	MADVIAND
a E	permit. Departm Importa any inju		21. Signature of Fundant Sorvice Licens	66	Ti	Name and Addre	ZE TUER	TNC FI	NERAL HO	ME 21224
_	80 E 8 9		Maria	Marine	7	00 s. c	ÖNKLING	STREET	,BALTIMO	RE, MD.
П			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not ent	ter the mode of dyin				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- 15CV	~ Mic	HEW	4 11	scase		Onset and Death
П	Examiner			Due to for as a cons	equence of):	Μ.	ellitus			W. K
		Je.	Se_uentially list conditions if any, leading to immediate	Due to (or as a cons	equence of):	11 (CITIOS			7201
4	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	15c	5+4					YTa'S
8760°A	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as a cons	equence of):					
	icate be executed physician and s the burial-transit	dlcal		d						
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pred	nancy				22d Date of de	
Вох	death a atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
<u>о</u>	that the death ed by the atte detached for	hys	9 Unknown	9□Unknown						
	es De	by Physician/Me	Part II. Other significant conditions con	ntributing to death but not i	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord	w requir been si should	ted						1 🗆 Y	es 2 No 3 P	obably 4 Naknown
Vital Records,	e law has b	Completed						24a. Was a autop	sy prior to	topsy findings available completion of cause of
a			05.11			·		perfor	med? death? 2 No 1 ☐ Yes	2 No
	ysician: The Is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth		ith <i>(Check only or</i> lome 5.2 Resid		
o	문 부 등	h: T	27. Manner of Peath	28a. Date of Injury (Month, Day Year,					ence 6 □Other (<i>Spe</i> ow injury occurred	city)
Sion	andin sath. or: Aff	atlo	1 Natural 5 Pending investigation	(World, Day 1 day	Injury		Yes 2□No			
Division of	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	pital ours a seral Deral		29a. Certifying Phy	nicion. To the best of my	tana da da da da da da da da da da da da da					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed (Mont	h, Day, Year)
	/			- Was		Dy	1969		10/12/0	5
	'n		30. ami and ad tress of reson occ	ompleted cause of death (I	tem 23a) (Type,	Print)	das	6.00	Q /11.	mn
			31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature 2	10 74		ave	Saltry	Tree 11
	Sta Registr		OCT 1 4 2005	Marie St	BOSH					

			For State Registrar		State	of Ma	ırylanı	-	artment rtificate			and M	ental Hy	giene		5	33345
	Physicia /Medic		1. Decedent's Nam Anna Lil										2. Date of Da Month Octobe		, 200	(ear)5	3. Time of Death 4:20 pM
	Examin		4a. Facility Name (-				Cato	nsvi					County of		
	Funeral Director		5. Social Security N 212-10-1	126	6. Sex 1 ☐ M 2 ☑ F		(In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Date 2-13-19	y, Year)			place (State or Foreign ntry) Land
	faryland show	or	10a. State	10b. County Baltim	ore			, Town or Lo	cation							1	0d. Inside City Limits 1 ☐ Yes 2X No
	28a-f	Director	10e. Street and Nu		016		n/a		10f. Zip	Code				10g. Cit	izen of Wh	at Cour	
	h with	I D	3500 Geor	rgetown	Rd.				21	227				U.S	.A.		٠,
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 ₩ Widowed		ied 1 Tys	ecedent E Forces? as 2 14 Give or Dates:			Was Deced f Yes, spec 1 Yes 2	ify Cubai	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race Black,	White,	etc.
2	thin 72 ho e. en "natur Medical	Completed	(Spec		t grade complete	ed)	+)	`life.	kind of wor DO NOT us	rk done d	lurina most	t of workin	g	16b. K	ind of Busi	iness/Ind	dustry
1	iled wi fygien her th nt, the		12 17. Father's Name	/Eiret Middle	(act)			Home 1	Maker		19 Matha	rin Nama	(First, Middle,		Home		
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ite M	To Be	William (Lagi)						Annie			Malueri	Sumame)		
la y	2 should and N ls man	-	19a. Informant's N							(Street a	ind Numbe	r or Rural	Route Number	-			Code)
5	1 and Health Iem 27		Errol A. 20a. Method of Dis		on		20b. P	lace of Dispo	sition (Nam	ne of		1 Rd	. Delma		MI) 21 ocation - C		wn, State
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	permit. Pages 1 and 2 should b Department of Health and Meniz Important: If item 27 Is marked any injury or other traumatic © 2008.	(21. Signature of Fi	ineral Service	Q N	Qb	OH	AI 2	Name and nbrose 719 Ha	d Addres E Fur ammor	s of Facility neral nds F	Home	of La Rd. La	nsde	owne	MD 2	1227
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5	cate be executed physician and the burial-transit	ai Examiner	that initiated event resulting in death)	S	cDue	todor as a	consequ	uence of):									years
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.00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 21 9 Unknown	noeths? □No	4□Pr	outcome over birth at the common terms of the	2 Fetal	death 3	Ectopic pro				<u> </u>		23d. Date Month		ery Day Year
20,0	juires that n signed b	by P	Part II. Other signi	ficant conditio	ons contributing t	o death bu	it not resu	ulting in the u	nderlying ca	ause give	n in Part I.			obacco (ute to th	ne cause of death?
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2	ysician: The is certificate hi director, page	Be C	25. Was case refe examiner?	rred to medical							26. Place	of Death	(Check only o				20110
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5	tending Ph leath. lor: After th the funeral	ation	1 Accident	5 Pendin investig	g (A gation	ate of Injur Month, Day	Year)	28b. Time of Injury	M	8c. Injury Work 1 🗀 Y	at :? ∕es 2 ∐ ñ		8d. Describe I	now injui	ry occurred	1	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 4 Homicide	6 Could determ	ined 286. Pl	ace of Inju uilding, etc	ry - At ho . (Specify	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tov			or Aura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	1 entifyin 2 Medical	g Physician: To Examinar: On th and m	the best of e basis of nanner sta	examinat	wiedge, deati tion and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manr d place, an	ner as st d due to	ated. the cause(s)
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				A . T		AND THE PARTY		-									

State of Maryland / Department of Health and Mental Hygien 05 33346 1 - For State Registra Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) Examiner City, Town, or Location of Death County of Death Havei Hunder 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🖫 F Director Yrs. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits other treumatic event, the Madical Examiner must be nutified at 1 Yes 2 No Director viaru land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Itams 23a Vani by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours efter and Mental Hygiene. Is marked other then "netural", or Ita 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ma 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ami 19a. Informant's New e/Relationship (Type, Print) 199. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Ame 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages I Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Auburn Cemeter 110 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li xinsee 22. Name and Address of - cility Home, neval passes to 21216 North 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequents of) Examiner cause. Enter Underlying Cause (Disease or injury certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown à signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No Completed 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 No □ Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 2 🔛 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of After t 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28595 12 succes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUD M121208 KNEEM 31. Date filed (Month, Day, Year) 32. Signature State OCT 1 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 205 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death pay th 3. Time of Death WRIGHT Year **Physician** Month MARY 6.50 A.M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Baltimore Co. Randallstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 219-28-3171 70 Yrs Director Scranton PA 4, Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at MD Baltimore Co. Owings Mills 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 213 Embleton Rd 21117 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Interportent: if Item 27 is marked other than "natural", or Item Important: if Item 27 is marked other than "natural", or Item Applicant Examination of the Medical Examinations. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: 3 Wildowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home Own 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nozeika Mary Ann Corcoran Leo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela L. Welborn Daughter 10 Triple Crown Court Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St Stanislaus Cem. 10/15/05 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBRO VASCUAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Indon, in Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death Yes 2 No the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disace (Sunau 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2010 or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Pay, Year)

October 137 2005 29b. Signature and title of certifier 29c. License number 054288 Motheret togrited conte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 5 33348 For State Registrar Amend Item #19a Per FH C849 Certificate of Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:20 AM M 10 12 2005 Robert Joseph Wierman, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis <u>Anne Arundel Medical Center</u> Anne Arundel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Davs 1**X** M 2□ F Hours Min. Director 58 09/08/1947 192-34-0263 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 ▼No Baltimore Hydes Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 Williams Road 21082 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Vietnam Year or Dates: Fra 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No β Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Electrical Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Robert Joseph Wierman, Jr. Frances Keffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Williams Road - Hydes, Maryland Elizabeth J. Wierman / wife 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdns. 10/15/2005 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 0 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction **Physician** Myocaronal MIM C resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 has autopsy performed certificate 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient P 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certified Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 446001 Physicma 105 X 6 person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 9512 HAGEORD Rd # 4 31. Date filed (Month, Day, OCT 1 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2005Certificate of Death

2. Date of Death

Month

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

OCTOBER 11, 2005

Year

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/Medi Examir **Funeral** Director **Physician** /Medical Examiner

1. Decedent's Name (First, Middle, Last)

3. Time of Death

n	EVERE-	-TE E	ر میران	ue (1	/ATTS							Month October	Day		Year Zoo	1:1	1 PM
ıl r	4a. Facility Name (4b. (City, Tov	vn, or L	ocation	of Death				of Death		,
	BALTIMURE	= 1/A	Men	WAL C	ENTER					nor					1/A		
	5. Social Security N		6. Sex		7. Age (In yrs	. last birt		nder 1 Y	ear	If Unde	r 24 Hrs.	8. Date of Bi	th		9. Birthpl	ace (Stat	e or Foreign
	220-14-8		1 X	M 2□F		85	Yrs. Mon	ths D	ays	Hours	Min.	May 5,	1920	0	Tenne	(rv)	_
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	Maryland		•	ore Co		ity, Towr	or Location Pa	rkto	٦n						10		City Limits es 🎗 🖫 No
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	1911 Fa1:		d				101		1120)			rog. Citi	zen ot v	hat Coun	try? US	SA
	11. Marital Status			12. Was Dec	cedent Ever in U	J.S.	13. Was D	ecedent	of Hisp	anic O	rigin? (S	pecify Yes or No o Rican, etc.))-		- America		,
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	(Spec	15. Decede)	16a.	Decedent's (Give kind o	f work d	one du	on ring mo	st of wor	king	16b. Kir	nd of Bu	siness/Ind	ustry	
	Elementary/Second 12	ndary (0-12)		College	(1-4or 5+)	Wi	` <i>iit⊕. DO NC</i> reman/		,	rici	an			vate	turi	. C	
	17. Father's Name	(First Middle	last)			1						ne (First, Middle				ig oc	·
	Tom Lee 1		,,									Gilbert			9)		
	19a. Informant's N	ame/Relation	ship (Ty)	pe, Print)		19b.	Mailing Add	ress (St	reet an	d Numb	er or Ru	ral Route Numb	er, City o	Town,	State, Zip	Code)	
	Ronald Wa	atts		Son		19	11 Fa1	ls F	Road	l	Park	ton, Ma	ryla:	nd 2	1120		
	20a. Method of Dis XXBurial 2 4 Donation			emoval from	State	cemeter	Disposition y, crematory n Park	or other	r place)		10/1	Date 4/2005			re, N		
	23a. P. En er I shock, or hea Immediate Cause disease or condition resulting in death)	(Final	r ompli t only on	Pn	used the deach line.	~	ot enter the	mode of	dying,	Roa such a	d s cardiac	Baltimo or respiratory a	re, rrest,	Mary		Approxim Interval E Onset an	Between
	Sequentially list co if any, leading to ir cause. Enter Under	nmediate erlying	Į		o (or as a conse	quence	of):										
	that initiated event resulting in death)	5	°	Due to	(or as a conse	quence	of):										
				J													
	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ⊒ No	2	1 Live	utcome of pregr birth 2 Fet gnant at time of nown	al death	3 □Ectop 5 □ Othe						2	3d. Date Mor	e of deliver	ry Day	Year
	Part II. Other signi	ficant condi	tions con	tributing to	death but not re	sulting in	the underly	ng caus	e given	in Part	l.	23e. Did	obacco u	se contr	ibute to the	e cause (of death?
													Yes 2				Unknown
-										· · · · · · · · · · · · · · · · · · ·		24a. Was auto perfe 1 \(\text{Yes}	psy ormed?/	P	Vere autop rior to com leath?	npletion o	gs available f cause of
	25. Was case refe	red to medic	al						- 2	26. Plac	e of Dea	th (Check only	one)				
	examiner?	No	Н	lospital:	Inpatient 2] ER/Ou	tpatient 3[DOA	Other	4 🗆 N	ursing H	ome 5 Res	dence 6	Othe	er (Specify)	
	27. Manner of Dea 1 Natural 2 Accident	5 Pend	ling stigation		of Injury nth, Day Year)		ime of njury M	28c.	Injury a Work?	it s 2 [28d. Describe	how injury	occurr	ed		

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Certifica

Medical

3 🗍 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

> State Registrar

BIZYAN MAX 31. Date filed (Month, Day, Year) OCT 1 4 2005

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREEN

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number P 19775

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.0 5

		•	For State Registrar	State of Ma	arytariu / L	Cert	ificate of	Death	wentar my	Reg. No.	CUUS	333	50
y.	Physicia	an	Decedent's Name (First, Middle, La	•					2. Date of Do Month		Year	3. Time of	Death
	/Medic	al	CATHERINE		USME				OCTOR	3CPC	13,20	3:15	- AM
Adap	Examin	er	4a. Facility Name (If not institution, give Howard County)	_	11000		4b. City, Town, o		th		County of De		
7.5	Funeral		5. Social Security Number 6.5		e (In yrs. last bir	thday)_		If Under 24 Hrs	8. Date of Bi	rth	towa		or Foreign
	Director		213-20-1451	□M 2GkF	89	Yrs.	Months Days	Hours Min	5-7-19	ay, Year) 16	Ma	irthplace (State of Country) ryland	c. c.g.,
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation					10d. Inside Ci	ity Limits
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	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What (Country?	
	23a c	aiD	1039 Downton Rd				21227			U.S.	A .		
2	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentall Hygiene. Important: If term 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notilified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba Yes 2 No	ispanic Origin? (S in, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)		4. Race - An Black, Wh Specify:Wh		
	72 hou	Completed	15. Decedent's E (Specify only highest gra	ducation	16a.		nt's Usual Occup		ndring	16b. Kir	d of Busines	s/Industry	
7	ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5	(i+)	life. Do	O NOT use retired	d)	, Kuig	Ret	o i 1		
4	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	- 01	.elk		18. Mother's Na	me (First, Middle				
8	Mental Ked o	To Be	Clarence E. Harig	5				Etta Ca		,	3011101		
Wal y	ind 2 should be of the and N is 27 is mail or traumail		19a. Informant's Name/Relationship (Kathy Kasakitis/I						ural Route Numb kesville			Zip Code)	
5	Peges 1 and nent of He ant: If Item ant: or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ ☐ ☐ ☐ ☐ Other (Special Content of Conten		Crest 1	f Disposi ry, crema awn len	tion (Name of atory or other place Memoria	î 10-	Date 17-2005			Town, State	
חשור	permit. Departr Importu any inju		21. Sprintule of Funeral Service Libe	SOCA	M				me Inc.				
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the eath. Do							Approximate Interval Bet	ween
	Physician (Madical		Immediate Cause (Final disease or condition resulting in death)	a. RESP	RATOR	24	FAILUR	E				Onset and to	
	/Medical Examiner		1		a consequence		ART K	MI UNZ C				12 Da	410
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		a consequence								147
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Myor	BROIT	YL.	INFA	RCTIO	U			12 0	mys.
5	be ex icien a	al E	rosuming in doutry cast	Due to (or as	a consequence	of):							
	ficate g phys	edicai	•	d									
5	eath certificate be executed attending physicien and for use as the burial-fransit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □ □	Ectopic pregnancy			2	3d. Date of d	elivery	
	that the deal led by the att detached fo	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 🗆 (Other (specify)				Month	Day 1	Year
, (2)	w requires that been signed I should be det	þ	Part II. Other significant conditions of ACUTE REP			n the und	derlying cause giv	en in Part I.		tobacco us Yes 2 🛭		to the cause of d Probably 4 ⊕ €	
	The la te has age 2	Completed	Hyperrous	icon.					24a. Was auto perfe 1 Yes	psy ormed?	prior to death?	autopsy findings a completion of calls	available ause of
	idcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						ath (Check only				
5	Physi this c	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie			3□ DOA Oth	4 🗆 Nursing	Home 5 ☐ Res			ecify)	
200	ttending Physicien: Jeath tor: After this certifica	Certification:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b			Time of Injury		yat k? Yes 2 □ No	28d. Describe				
2	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		4 Homicide determined	building, et	c. (Specify)				City or To	wn, State)		Rural Route Num	ber,
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	29a. Certifier 1 Cartifying PI (Check only one) 2 Madical Example 1	ysician: To the best ninar: On the basis of and manner sta	examination an	e, death o	occurred at the tine estigation, in my o	ne, date and plac pinton, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner a place, and di	as stated. ue to the cause(s)
	To the To the comp	W	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Moi	nth, Day, Year)	
)	3		88hem		cm		042	-680		Icro	BER 1	3 200	5-
	6		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Pi	rint)	0	4C E		1	00.0	
	τ		SABA SITEHULL 1	וצטף עית	DUM	ORGI	VATIONAL	. TIKE SP	AC EL	1100	TCITY	11111 21	642
13	Sta	te	31. Date filed (Month Day, Year)	32. Figistr	ar's Signature		10 -	,			1	11/2	7/

					yland / Depa	artment of Health and tificate of Death	d Mental Hygie	_	33351
		Physici /Medio		Decedent's Name (First, Middle, Last) Frederick Charles Zander			2. Date of Death Month October	Day Year 10, 2005	3. Time of Death 7:00 p M
		Examin		4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Location of De Havre de Grace		4c. County of Death Harford	
		Funeral Director	200	214-30-7068 ^{1 M 2 F 72}	In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	8. Date of Birth (Month, Day, Y	rear) 9. Birthpl Count 1933 Mary	lace (State or Foreign try) 1and
		Maryland f show	ō	Usual Residence of Decedent	Oc. City, Town or Lo	cation Abingdon		10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
		with the N N or 28a-	Director	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Count	try?
	9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. The Medical Exam national be notified at ance.	Funeral	2915 Craigston Lane 11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give	er in U.S. 13. V	21009 Nas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu □ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	U.S.A. 14. Race - America Black, White, 6 Specify: Whi	etc.
	21215-0036	n 72 hours "natural", edical Exe	leted by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of the DO NOT use retired)	working 16	Sb. Kind of Business/Ind	
	d 212	filed withir Hygiene. other than	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 years 17. Father's Name (First, Middle, Last)		ration technici	an {	government	
	Maryland	nould be d Mental narkad c	To Be	Walter Zander	401.44.75	Della		,	
	, Mai	and 2 st ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) Rita B. Zander/wife	2915	g Address (Street and Number or Craigston Lane,	Abingdon,	Md. 21009	
md 00	Baltimore,	Pages 1 ment of H ant: If ite ury or oth		20a. Method of Disposition 1 Disposition 1 Disposition 3 Disposition 3 Demoval from State 4 Donation 5 Other (Specify)		sition (Name of natory or other place) Mem. Gdns. 10/		el Air, Md.	
8	Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Percel		Name and Address of Facility Schimunek Funera	1 Home of	Bel Air, In	nc.
05		Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition or start of the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	or the mode of dying, such as card	liac or respiratory arrest		Approximate Interval Between Onset and Death
01/0	68760,	certificate be executed iding physician and ise as the burial-transit	ical	resulting in death) Last Due to (or as a c	onsequence of):				
Ϋ́			Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
GIIC	rds, P.	The law requires that the death to has been signed by the atter bage 2 should be detached for L	by	Part II. Other significant conditions contributing to death but r	not resulting in the un	idertying cause given in Part t.	23e. Did tobac	cco use contribute to the	e cause of death?
Frederick		iician: The law requ certificate has been rector, page 2 should	Completed				24a. Was an autopsy performe	prior to com	osy findings available appletion of cause of
1	Vital	Physician: this certificatal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Toppatient	2 ER/Outpatient	Othor	eath (Check only one)	ce 6 □Other (Specify)	1
ander	ion of	To the Hospitel or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	atlon: T	27 Manner of eath 1 Natural 5 Pending 2 Accident investigation 28a, ate of Injury (Month, Day Y		28c. Injury at Work? M 1 Yes 2 No	28d. Describe how)
1231	Division	To the Hospitel or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
		the Hospi nin 24 hou tha Funar npletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of representation one) 1 Medical Exeminer: On the basis of example and manner states.	camination and/or inv	restigation, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
		5 1 × 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2	29b. Signature and title of certifier	MA	29c. License number	42 10	Date signed (Month, D	Jay, Year)
	V	11/2		30. Name and address of person who completed use of deat Trins MIM MUM MUMSKA 4	ET HE	Print) pord me	morial	2 Hos	pitel
	1	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrats	Signature			0	

DHMH 17 Rev 1/2001

			1 - For State Registrer	ate of Maryland		rtment of Hetificate of L			giene 0 0	15	33352
	Obveisi		Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		CLARENCE LYNN ABEL						*	2005	7:47 p M
	Examin	er	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Deatl	1	4c. County		
			5. Social Security Number 6. Sex	7. Age (In yrs. last	hirthday)	Hyattsv If Under 1 Year	ille If Under 24 Hrs.	8. Date of Birt			orge's
	Funeral Director		154-18-8736		Yrs.	Months Days	Hours Min.	April 1	y, Year)	Count	lace (State or Foreign try) 15ylvania
	Q		Usual Residence of Decedent					MILL I	7, 1520	1 Cilli	Bytvania
	arylar show	١	10a. State 10b. County	10c. City, To	own or Lo	cation				10	0d. Inside City Limits 1 X Yes 2 □ No
	he M	Director	Maryland Prince Geo 10e. Street and Number	rge's Hyati	svil						
	a or 3	ā	6000 42nd Avenue			10f. Zip Code 20781			10g. Citizen of W	hat Count	iry?
	death ms 23	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S.	13.	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	U.S.A.	e - America	an Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then them 23a or 28e-f show item 27 is marked other then "neturel; or Items 23a or 28e-f show other treumatic event. It is Modical Examble must be notified at	þ	t Never Married 2 Married 1	med Forces? MYes 2 □ No WWI] Yes, Give ear or Dates:	f	f Yes, specify Cubar ☐ Yes 2 🖾 No	Specify:	o Rican, etc.)	Specify:	k, White, e Whi	
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade con	n (1)	Sa. Deced	lent's Usual Occupa	tion	tina	16b. Kind of Bu	siness/Ind	lustry
2	within ene then "	mple	Elementary/Secondary (0-12)	ollege (1-4or 5+)		kind of work done d OO NOT use retired)					Schools
2	iled w tygiei her ti		12 17. Father's Name (First, Middle, Last)	A	udio	Visual T			Prince Maiden Surname		ge's County
anc	2 should be filed v n and Mental Hygie 'is marked other t reumatic event, IL	Be c	unavailable				unavail		Maiden Surname	3)	
Z	should nd Me mark imati	2	19a. Informant's Name/Relationship (Type, P	rint) 1	9b. Maitir	g Address (Street a			er. City or Town.	State. Zin	Code)
	alth a 27 is		David L. Abel - Sor			Hedgewood					
Je,	of Health of Health litem 27 i		20a. Method of Disposition	20b. Place		sition (Name of natory or other place		Date	20c. Location -		
Ē	Page nent o		1 XBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai iioiii State		In Cemete	1	1/2005	Brentw	ood,	Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	1 4		. Name and Address			ıneral H	ome,	P.A.
	205 8 9		Claudette Dasce	holanning		739 Balti:				MD 2	20781
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	use on each line.		or the mode of dying					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):			•			
ı	Examine	ų.	Sequentially list conditions, if any, leading to immediate	M	19C	GNAN	1 ME	CANON	404		·
	ted	Examiner	cause. Enter Underlying	Due to (or as a consequent	e of):						
	axecur and al-trai	xan	Cause (Disease or injury that initiated events c c	Due to (or as a consequence	ce of):					-	
68760,	icate be executed physician and s the burial-transit	edicai E	d.								
_		ledi									
Вох	eath certific attending pl	an/N	200. Was decedent program	yes, outcome of pregnancy □Live birth 2 □ Fetal dea	ath 3□	Ectopic pregnancy				e of deliver	*
	at the dea by the at tached fo	Physician/M	1 Yes 2 No	Pregnant at time of death		Other (specify)			Mon	ith l	Day Year
P.0	that the		Part II. Dther significant conditions contribu	ting to death but not resulting	g in the u	deriving cause give	n in Part I	23e Did to	phacco use contr	bute to th	e cause of death?
Vital Records,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	ted by		RTENSION	9						ably 4 \(\frac{\text{\text{Unknown}}}{\text{Unknown}}\)
ecc	e law r has be	Completed						24a. Was autop	isy p	Vere autop	osy findings available
H H		Con							rmed? d	eath?	
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al· _	-	Otho		th Check on o			
of	Phys f this sral di	To:	1 165 \$ 140	a. Date of Injury 28	Outpatien D. Time of	t 3 DOA	* 4 Nursing H		dence 6 Othe)
lon	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 🗀 Y	? ′es 2 □ No				
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home building, etc. (Specify)	farm, str	eet, factory, office			Street and Number	er or Rural	Route Number,
Ö	tel or A rs after el Direc ed in by	Cer		building, etc. (Specify)				City or Tou	m, State)		
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical	(Check only 2 Medical Examiner: (n: To the best of my knowled on the basis of examination and manner stated.	ige, death and/or in	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the cred at the time,	cause(s) and mar date and place, a	ner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. License	number		29d. Date signed	•	
,			1 4 auca	Mo		D	63200	90	9(3	nos	
. ار	5) (Va		30. Name and address of person who comple								2 . 2 0
			SUPLESIAKUMBA M. 31. Date filed (Month, Day, Year)	Begistrar's Signature	30	UEENSOU	RY RJ	5776 Y 63	Jille,	MD	30181
	Sta Registr		OCT 0 3 2005	2. Registrar's Signature	Agra	le					

			1- For State of Maryland / E	•	artment of Health and	, ,	ene 2005	33353	
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) John David Bishop 4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Location of De Hagerstown	2. Date of Death Month C +	Day Year 3. Time of Death 12.22 M 4c. County of Death Washington		
	Funeral Director			rthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		1	thplace (State or Foreign puntry) Lrginia	
	Marylend -f ehow lied #1	lor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Md. Washington		cation			10d, Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the ta or 28e	Direc	10e. Street and Number	10f. Zip Code 21740	10	og. Citizen of What C	•		
920	d within 72 hours after deeth with the Marylend Jene. r then "naturel", or Items 23a or 28e-1 ehow the Medical Examiner must be notified at	by Funeral Director	17734 Virginia Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Nover 1 Nover 1 Nover 1 Nover 2 Nover 1 Nover 2 Nover		Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu I ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,	
21215-0036	d within jiene. r then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	vorking	6b. Kind of Business Constr	•			
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other treumatic event,	To Be	17. Father's Name (First, Middle, Last) John B. Bishop			lame (First, Middle, M Mary K. Wi			
	is 1 and 2 sho of Health and Item 27 is my other treum				g Address (Street and Number or Virginia Ave.				
Baltimore,	Peges 1 arent of Heam ht: If Item ry or othe		Dulla 2 Contractor 3 Denotive Tom State		sition (Name of natory or other place) org Crematory		Oc. Location - City or Smithsbure		
Balti	permit. Peges 1 Department of P Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Licensee	22	. Name and Address of Facility L. Davis Funera		25 Bradbu	-	
	Physician	_	23a. Part1. Enter the disease, or complications that caused the death. Dor shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		er the mode of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between Onset and Death	
8760,	Medical Examiner bhysician and sthe burial-transit	dicai Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	Mc	tue Pulmonar	ry Disers		
.O. Box 6	death certif e attending d for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy		23d. Date of de Month	ivery Day Year	
<u>a</u>	9 P ed	by	Part II. Other significant conditions contributing to death but not resulting in	n the ur	iderlying cause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?	
of Vital Records,	The law ate has b page 2 st	Completed	Stroke Sergine Hyperten		autopsy prior to completion of cause of death?				
on of Vit	Attending Physician: r death. ector: After this certific by the funeral director.	tion: To Be		utpatien Time of Injury	0.4	leath (Check only one Home 5 Residen 28d. Describe how	nce 6 Other (Spe	cify)	
Division	or Attendated after deat Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office	28f. Location (Stre City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospitel or Attent within 24 hours after deatl to the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	ed/or inv	occurred at the time, date and pla restigation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)	
*	To the vithin 2 To the complet	× ×	29b. Signature and title of pertitier		29c. License number	7	d. Date signed (Mont	h, Day, Year)	
7	XX		30. Name and address of person who completed cause of death (Item 23a) (l,	It litra, 1	16 317	¥0	(
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2005 32. Registrar's Signature	19	rese				

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State of Maryland / Department of Health an	nd Mental Hygien	005

For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death October Year **Physician** М BURTON HOLLACE BEST 2:5 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. J. (Months, 34). Year) 29 5. Social Security Number Birthplace (State or Foreign
 CMARYLAND 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1⊈M 2□F 76 Yrs. Director 579-34-1057 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No MARYLAND WASHINGTON BOONSBORO Director 10e. Street and Number 10f. Zip Code -10g. Citizen of What Country? ö or Itams 23a 21713 601 NORTH MAIN STREET U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TYPes 2 No If Yes, Give 1952 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 'naturel', WHITE other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary (6-12) College (1-4or 5+) OWNER/OPERATOR GRAPHIC DESIGN and Mental Hygie Is marked othar t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD THOMAS BEST ALTHA OTHELIA POTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 601 N. MAIN STREET, BOONSBORO, MD EILEENE V. BEST, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) BOONSBORO CEMETERY 10/05/05 BOONSBORO, MARYLAND 21. Sign ture Queer S rvi e Licensee 7606 OLD NATIONAL PIKE 22. Name and Address of Facility Kelly Zimerman 21713 BAST FUNERAL HOME BOONSBORO, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician doys disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Chrone 2 □ No 1 ☐ Yes 2 No 1 Yes Mna Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certiffe 29d. Date signed (Month, Day, Year) VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Delap Medic orto 11110 31. Date filed (Month) Day, Year) 32. Pegistrar's Signature OCT 0 3 2005 Registrar

			For State Registrar		State	e of Ma	aryland			nt of F te of			Mental Hy	giene Rag. No.		5	33355
4	Physici		1. Decedent's Nam TERESA			IN							2. Date of D Month Septer	Day		 'өаг)05	3. Time of Death 9:20 A M
0	/Medic Examin		4a. Fecility Name (an Hosp		d number)				. Town, o		on of Death		4c.	County of	Death	V
2	Funeral Director		5. Social Security (Number	6. Sex 1 ☐ M 2 🔀		63 (In yrs. I	ast birthday) Yrs.	If Unde Months	Days	If Und	ler 24 Hrs. s Min.	8. Date of B (Month, D June 7	irth	9	9. Birthp	lace (State or Foreign
	ryland		Usual Residence of 10a. State	10b. County			10c. City	r, Town or Loc	cation								0d. Inside City Limits
	deeth with the Maryland ime 23a or 28a-f ehow ir must be coulded at	Director	Md. 10e. Street and No		gomery		Ro	ckvill	_	ip Code	_			10a Citi	zen of Wh	at Cour	1 ☐ Yes 2 ☒ No
	th with 23a or	al Di	1050 Ca		Drive				101.22	208.	50				ed St		•
036	or ite	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed		ned 1 🗍 Y	Decedent End Forces? Yes 2 1 No. S, Give or Dates:		l1	Yes, sp	edent of Heading Cuba 2111 No	lispanic an, Mexic Speci	can, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours atter Deportment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "nature!", or Ite any injury or other treumatic event, the Medical Examination.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Administrator						durina m	ion If the Lind of Building most of working Educat				.,			
land	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name Willia		Last) ardo Jr.								ne (First, Middle te Jari		Sumame)		
Mary	12 should he and he reuma		19a. Informant's N				>						ral Route Numi				Code)
Tore, I	ages 1 end nt of Heeltl :: If item 27		20a. Method of Dis	sposition	aldwin (rom State	20b. PI	ace of Dispos emetery, crem	sition (Na natory or	ame of other plac	сө)	Octo	ckville Date ber 3,	20c. Lo	cation - Ci	ity or To	
Baltimore,	permit. Pa Departmen Important: any njury		21. Signature of F		Licenses	mbmeni	t Ft	Linc	. Name a	and Addre	ss of Fa	: 200 ^{cility} DeV	ol Fune	eral	ntwoo Home		d. 20877
29-05 9-00 cm	Physician produced by sicial physician and produced by sicial transit	dical Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or conditions and the second state of any, leading to cause. Enter Und Cause (Disease of that indicated even resulting in death)	on tallors. List	a Du	hat caused on each lin	COC a consequ a consequ	ATTC uence of): uence of):					or respiratory	arrest,			Approximate Interval Between Onset and Death SMONTHS
.0. Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?	1 DL 4 DP	s, outcome ive birth Pregnant at Jnknown	2 Fetal	death 3	Ectopic Other (s	oregnancy specify) _	1			2	23d. Date of Month		ry Day Year
rest P	.= v)	۵	Part II. Other sign	ificant conditi		to death bu			nderlying	cause giv	en in Pa	rt I.					e cause of death? ably 4 Unknown
Saldwin, Teres Division of Vital Records,	The law requ ete has been page 2 should	Completed					-						24a. Wa auto perf 1 □ Yes	opsy formed?	7 098	ore autopor to cor ath?	osy findings available npletion of cause of
. ⊂ Vita	sicien: certific rector,	Be	25. Was case refe examiner?		Hospital:	4				OA Oth	or		th (Check only	one			
Idwin sion of Vit	To the Hospital or Attending Physicien: The law within 24 hours effor death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ıtlon: To	1 ☐ Yes 2 27. Manner of Dea 1 ☐ Maturat 2 ☐ Accident	ath 5 ☐ Pendir	28a. C	1 Inpatie Date of Injur Month, Day	y	ER/Outpatien 28b. Time of Injury		28c. Injur Wor			ome 5 Res 28d. Describe				")
Selloris	al or Atters selter dea	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 Could detern	ined 288. F	Place of Injudual	ury - At ho c. (Specify	me, farm, stre	eet, facto	ry, office				(Street and own, State		or Rura	l Route Number,
(40)	he Hospit in 24 hour he Funera pletely fille	Medical (29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physician: T Examiner: On t and	o the best of the basis of manner sta	examinat	wledge, death ion and/or inv	occurre	d at the tir n, in my c	me, date	and place, leath occur	, and due to the rred at the time	e cause(s) , date and	and mann place, and	er as st	ated. the cause(s)
	To t To t	Σ	29b. Signature an	7-6)					C. Licens					_		Day, Year)
	10		30. Name and add		Who completed	cause of de	eath (Item	23a) (Type, I		0-2					1:3		
			VICTOR	M. PRI	E60,140	64	20 Rc	KKLEPE	EP	e. #	41cc	St	THESA	2,11	0 20	81	7
	Sta Registi		31. Date filed (Mo	CT 03	2005	Hegistra	ars Signal	me A	es.								

			1 - For State Registrar	Sta	te of M	larylan	d / Depa <i>Cei</i>	irtmen <i>tificat</i>	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. No		5	33356
			1. Decedent's Name (First, Midd	lle, Last)			-					2. Date of De	ath			3. Time of Death
	Physicia /Medic		Howard Branham										Da er 1		ear	6:55 P M
	Examin		4a. Facility Name (If not institution	on, give street a	nd numbe	r)		4b. City,	Town, or	Location of	of Death		40	. County of		
			Westminster N	ursing	and F	Rehab	Center	Wes	stmi	ster				Carro	11	
	Funeral		5. Social Security Number	6. Sex		ge (In yrs.	ast birthday)	If Under Months		If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year	, 9	. Birthpl	ace (State or Foreign
	Director		227-46-8885	1 X XM 2[7-	6	6Yrs.					Oct 14	, 19	38 V		inia
	and *	}	Usual Residence of Decedent 10a. State 10b. Count	v		10c. City	y, Town or Lo	cation							10	Od. Inside City Limits
	/anyli	ö														1 □ Yes 2 No
	28e-1	ect	Maryland Carro	OTT	-	wes	tminst	er 10f. Zip	Code				10a Ci	tizen of Wh	ot Cours	to 2
	with	2	1234 Washington	Poad				211					USA	MIZON ON WALL	at Court	uyr
	ns 23	era	11. Marital Status		s Deceden	it Ever in U.	S. 13.1			spanic Ori	gin? (Spe			14. Race -	Americ:	an Indian
"	r iten	듄	1 ☐ Never Married 2 ☐ Ma	rried 1	ed Forces	?					, Puerto i	cify Yes or No Rican, etc.)		Black,	White, e	etc.
036	urs a	by	3 ☐ Widowed 4 XDivorce	If Y	es, Give ar or Dates			I □ Yes	2 □XNo	Specify:				Specify:	hite	e
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or liems 23e or 28e-f show ne Madical Examiner mat be notified at	Completed by Funeral Director	15. Decede (Specify only high	nt's Education	lotod)		16a. Dece	lent's Usua kind of wo	al Occupa	ition	t of worki	3.0	16b. K	Kind of Busin		
21	thin 7	ple	Elementary/Secondary (0-12)		lege (1-4o	r 5+)	life.	DO NOT U	se retired,	uring mosi	(OI WOIK!	19				
21	ed wij	Con	6				Busin	ess O	wner					omoti	ve	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle	, Last)								(First, Middle	, Maider	n Surname)		
yla	Men Men arke	၉	Charles Branum				_			Ida M	lae D	uff				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or liems 23a or 28e-f show any injury or other treumatic event, Ire Madical Examinations to other theumatic event, Ire Madical Examinations to other contractions.		19a. Informant's Name/Relation Howard J. Brant		nt)							Route Numb nchest				Code)
Baltimore,	s 1 a f Hea item othe		20a. Method of Disposition	_			lace of Dispo emetery, crer	sition (Nar	ne of	9)	Oct8	ber 3,	20c. L	ocation - Ci	ty or To	wn, State
Ē	Page nent c nt: If nry or		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (I from Stat	Θ !	Arunde	-		1		71		iton,	Mary	yland
a =	permit. Departminente importe any inju		21. Signature of Funeral Service	Licensøe	11.		C 22	Name an	d Addres	s of Facilit	y tion	Servi	00	PΛ	Roy	784
0	89 1 2 8		Bevery L	Hal	the	MO1										MD 21029
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications	that caus	ed the deatl										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		C.	VI	4									Onset and Death
	/Medical		resulting in death)	a	Due to (or a	s a conseq	uence of):									
-	Examiner		Sequentially list conditions,	b	D4	Sb	uga	,								
	p ti	Examiner	if any, leading to immediate cause. Enter Underlying	, '	Oue to (or a	s a con eq	uence 11:	1								
	and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c	1)-6	is a consequence	100									
8760,	cate be executed physician and the burial-transit	E)	,		1 0 00 00	S a conseq	uence or):									
87	phys the	dical		d	+ 4	2111v	-									
× 6	eath certifi attending		IF FEMALE:	23c If v	es outcom	ne of pregna	incv							0010	4 4 1	
Вох	that the death certifed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1	Live birth	2 ☐ Feta at time of d	Ideath 3	Ectopic pr						23d. Date of Month		ry Day Year
P.0.	0 0 0	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown		0411 3	J Owler (Sp	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	requires that the een signed by th nould be detache	/Ph	Part II. Other significant condit	ions contributir	ng to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	obacco	use contribu	ute to the	e cause of death?
ds	uires sign ld be	d by	chum	e PC	un	S	4 mb+	nm	c.			1 🗆	Yes 2	!□No 3	☐ Proba	ably 4 @Unknown
Š	~ Q 76	lete			,		1	-, -, -,	<u> </u>			24a. Was		Oah Wo		and findings are lable
Re	has has	ompleted										auto		prio dea	r to con	osy findings available npletion of cause of
a	en: Th tificate for, pag	O	OS Man annual to madia	-1								1 Yes	2 1 Ne	1 [Yes	2 No
Σ	ici Ger	Be c	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital	l: 4 🗆 !		50.0		Othe	100		(Check only				
of	Phys rthis ral di	. To	1 Yes 2 No	28a	1 ☐ Inpa Date of In		ER/Outpatier 28b. Time of		JA	4 (4-NU		ne 5 Resi			(Specify	")
on	ding the After funer	tlon	1 Natural 5 ☐ Pend	ing tigation	. Date of In (Month, L	ay Year)	Injury	м	28c. Injury Work 1 □ \	(? ∕es 2 🗀 l				ny coodinod		
Division of Vital Records,	Attending in death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	I not be	. Place of I	njury - At ho	ome, farm, str					28f. Location (Street a	nd Number	or Rural	Route Number,
Ö	after Dire	Certification:	4 ☐ Homicide detel	illied	building,	etc. (Specif	y)		,,			City or To				
	spite rours	aC	29a. Certifier 1 Certify	ing Physician:	To the bes	st of my kno	wledge, deat	occurred	at the tim	e, date an	id place, a	and due to the	cause(s	and mann	er as sta	ated.
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	edical	(Check only 2 Medica one)	il Examiner: Or	n the basis d manner	of examina	tion and/or in	vestigation	, in my op	inion, dea	th occurre	ed at the time,	date an	d place, and	due to	the cause(s)
	To the within To the comp	Me	29b. Signature and title of certif	ier				290	c. License	number			29d. Da	ate signed (/	Month, L	Day, Year)
			1111	Ci	ML	ca 1	NID	1) - 0	05	4-6	218	10	0	3.=	2005
7	2		30. Name and address of perso	n who complete	ed cause of					ſ						
5)			DR. Kaman	Bh	Cane	lug (349 1	viclo	17 12	du	14	LUCIA	52.12	cope	MD	211517
	Sta Regist		31. Date filed (Month, Day, Yea	3 2005	32. Regis	strar's Signa	ture				,					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

H- Wood JR.

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

M.D.

32. Registrar's Signature

For State Registrar

Car1

Physician

1. Decedent's Name (First, Middle, Last)

Herman

Ballenger

ORIGINAL

Soldlewild

4:25p M

Day 4, October 2005 4c. County of Death

Talbot Birthplace (State or Foreign Country)

> 10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country? United States

14. Race - American Indian. Black, White, etc. White Specify:

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Sumame)

2. Date of Death

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cambridge, MD 21613

20c. Location - City or Town, State Baltimore, MD

22. Name and Address of Facility Framptom Funeral Home, MD 21632

216 N. Main St., Federalsburg, Approximate Interval Between

23d. Date of delivery Month

Day

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and M 1- State Registrar Amend Items 23a, PtI, 25, 27, 28a-f. per MF, 6849, 11/	ental Hyg 29/05dh	iene b 2005	33358		
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death		
	/Medic	al	4a. Facility dame (If not institution, give street and number) 4b. City, Town, or Location of Death	arber	4c. County of Deat			
	Examin	er	The John Hodins Howital Rullimore Ci	Lu	Baltimo			
	Funeral		5. Social Security Number 6. Sex 7. Age Vin yrs. Vast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 22		aplace (State or Foreign		
	Director		Usual Residence of Decedent	June 22	,1943 Mar	yland		
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	8a-1s	cto	MD Dorchester Federalsburg	,		1 ☐ Yes 2√∑ No		
	th with the 23g or 2	Funeral Director	10e. Street and Number 6546 Eldorado Road 10f. Zip Code 21632		og. Citizen of What Co United St	•		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28a-1 show may injury or other traumatic event, the Medical Ever's last must be usuffied at ance.	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, specify Cuban, Mexican, Puerto Forces of this panic Origin? (Specify Cuban, Mexican, Puerto Forces of the Yes, Specify Cuban, Mexican, Puerto Forces of this panic Origin? (Specify Cuban, Puerto Forces of this panic Origin? (Specify Cuban, Puerto Forces of this panic Origin? (Specify Cuban, Puerto Forces of this panic Origin? (Specify Cuban, Puerto Forces of	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W			
5-0	"natu	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)	ng	16b. Kind of Business/	ndastry		
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	other	a	17. Father's Name (First, Middle, Last) 18. Mother's Name					
ylar	nould be a Mental Inarked o	To B	Clayton Lee Turner Annabe		atley			
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura					
	Health tem 27 other tr		Alison B. Taylor/Daughter 6546 Eldorado Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Talsburg, 20c. Location - City or			
E	Pages nent of int: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Cem. 10/0		Federalsb			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr QDCE.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fr. 216 N. Main St.,	amptom Feder	Funeral alsburg,	Home, P.A. MD 21632		
68760,	/Medical Examiner buystcian and buystcian site private its the	Physician/Medical Exan iner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last	ations		Interval Between Onset and Death		
О. Вох	ath certifi attending for use as			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delimenth	very Day Year	
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Vital Records,	aw as b	Completed		24a. Was ar autops perform 1 Yes 2	y prior to c ned? death?	opsy findings available ompletion of cause of		
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes She 1 X npatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home		e) ince 6 □Other (Spec	:4.1		
10	ng Phy ter thi	T: L			w injury occurred	(y)		
Siol	Attending r death. ector: After by the fune	catic	2 Accident investigation 09/24/05 Unknown M 1 Yes 2 Xivo	subjec	ct fell			
Division of	or Ati after d Direct in by	Certification:	4 Homicide determined building stee, (Specify)	City or Town	reet and Number or Ru , State)			
_	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Co	29a. Certifier (Check only onle) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca	use/s) and manner as	MD Federalsburs stated. to the cause(s)		
	To the within To the Compli	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	Day, Year)		
			Roan M. K. M. MO RES DOO		October 4	2005		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regar M. Kretzer, MD 6000 N. Wolfe St., &	011		. 0 =		
	Sta	te.	31. Date filed (Month, Day, Year) 82. Registrar's Signature	Delpha	re, MD 2	287		
	Registi		OCT 7 2005 And A And					

	A	State of Maryland / Department of Health and mend item #19a&b Per FH G848 10/14/0 Gertificate of Death		Reg. No.	33359
door	Physician Medical	VIRGINIA POHANNON	2. Dete of Dec Month octobel	Dey 2005	3. Time of Death 4:00 AM
1	Examiner	Eagle View Assisted Living Whitefor		Ha	rford
	Funeral Director	5. Social Security Number 6. Sex 1 D M 2 F 96 Yrs. 1 O M 2 F 3 Age (In yrs. lest birthday) 1 O M			thplece (State or Foreign ountry) Yland
	Sa-f show	10a. State 10b. County 10c. City, Town or Location Whiteford			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the Maryler 23a or 26a-f show tast be notified at	10e. Street end Number 626 Wheeler School Road 21160		10g. Citizen of What Co USA	ountry?
0000	urs after deceived, or fleme	If Yes, Give 1 \(Yes a cive of the	(Specify Yes or No- erto Rican, etc.)		
21215-0020	ed within 72 ho ygiene. ier than "netur it, The Waddell Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 11 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) Underwriter		16b. Kind of Business	
Maryland 2	should be filed ind Mental Hygi marked other umatic event, I	17. Father's Neme (First, Middle, Last) 18. Mother's N.	ame (First, Middle, Elizabeth	,	ance
	1 and 2 sho Health and Im 27 is mu ther traum	Dr. Edwin W. Whiteford/Newphew 19b. Mailing Address (Street and Number or to Deepwood 811 Beetwood Court, 20a. Method of Disposition 20b. Place of Disposition (Name of	Bel Air,	MD 21015	
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o	1 Daurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	10/10/05 D	20c. Location - City or Delta, Penn	
Ba	permit. Departr Importa any inj	Parkins Funeral Home, In 234. Perf. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardinated the shock, or heart failure. List only one cause on each line.			PA 17314
	Physician /Medical Examiner	Immediate Cause (Final disease or condition URD SEP S/S	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
W		Due to (or es e consequence of): CONGESTIVE HEAR!	FAIL	URE	> 2 4 EARS
8760, 7	E Per B	Ceuse (Disease or injury that initiated events	EXTLA	1	72 YEARS
Box 68		is solving in usality Last	NFARCI	7,060	7/04EARS
P.O.	the ache				to the cause of death?
Vital Records,	aw requir as been s 2 should pieted		24a. Was a perfor	med?	Were autopsy findings available prior to completion of cause of deeth?
/ital R	ysician: The law is certificate has b director, pege 2 s	25. Was case referred to medical examiner?	1 □ Yo		1 ☐ Yes 2 ☐ No
ō	is in	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 Reside	ence 6 DOther (Specow injury occurred	ASSISTEDLIVIA
Division	or Attendent after deat Director: I in by the	2 Accident investigation 3 Suicide 4 Homicide M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (SI City or Town	treet and Number or Ru n, Stete)	iral Route Number,
	To the Hospital within 24 hours and to the Funeral completely filled	29a. Certifier (Check only one) 1/* Certifying Physician: To the best of my knowledge, death occurred et the time, date end plac 1/* Certifying Physician: To the best of my knowledge, death occurred et the time, date end plac 1/* Certifying Physician: To the best of my knowledge, death occurred et the time, date end plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 4 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 5 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place 5 Medical Examiner: On the basis of examination and/or investigation and occurred et the time, date end place 5 Medical Examiner: On the basis of examination and/or investigation and occurred et the end place 5 Medical Examiner: On the basis of examination and occurred et the end place 6 Medical Examiner: On the basis of examination and occurred et the end place 7 Medical Examiner: On the basis	urred et the time, d	ate and place, and due	to the cause(s)
	£ ₹ £ § ~	Marker, Valgar rep. DØ0 163.	89	9d. Date signed (Montl	n, Dey, Yeer)
	State	31. Date filed (Month, Day, Year) 3 Registrer's Signature	ed ROAD	Su. 106 7.	ALLSTON HO
	Rogietrar	OCT 1 4 2005 Francis A April 1			

DHMH 16 Rev 6/95

			For State of Registrar	f Maryland / Dep	artment of H			2005	33360	
8	(F) \$		Hegistrar 1. Decedent's Name (First, Middle, Last),		711110010 01 2	2.1	Date of Death		3. Time of Death	
	Physicia /Medic		Leonh. Br	van		6	Month Da	8 2005	750 9 M	
)	Examin	1000	4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or	Location of Death	40	. County of Death		
7.			Holy Cross Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Silver If Under 1 Year		Date of Birth	Montgome	ery place (State or Foreign	
	Funeral Director		239-30-9033	78 Yrs.	Months Days		Date of Birth Month, Day, Year		th Carolina	
le.			Usual Residence of Decedent	10c. City. Town or L		100	pc. 10,		10d. Inside City Limits	
	ehov	ō	10a. State 10b. County Maryland Montgomery	Rockvil					1 ☐ Yes 2 🗷 No	
	288-1	Directo	10e. Street and Number	ROCKVII	10f. Zip Code		10g. C	tizen of What Cou	untry?	
	h with		13216 Dumbarton Drive		20853			USA		
	ems or m	Funeral	Armed For	rces?	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White		
36	rs afte	by Fu	1 Never Married 2 Narried 1 Yes If Yes, Giv. 3 Widowed 4 Divorced Year or Da	2 No re ates: 1949-65	1 ☐ Yes 2√€ No	Specify:		Specify:Whit	te	
2-003	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f ehow na Modical Examiner must be incillised at		15. Decedent's Education	16a. Dece	edent's Usual Occupa		16b. l	(ind of Business/li		
	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-	-4or 5+) life.	DO NOT use retired	during most of working ()				
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)	Enç	gineer	18. Mother's Name (Fi		efense Co	ntract	
and	Duld be f Mental h arked of	To Be	Troy Edward Bryan			Martha Li]		,		
Maryland 2121	d 2 should be filed within 72 hour h and Mental Hygiene. 7 ie marked other than "natural traumatic event, the Medical Ex	۴	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a	and Number or Rural Ro			ip Code)	
	1 and 2 Health a tem 27 ic		Shirley J. Bryan/ Wife			on Drive, I				
timore,	S to I		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 5	State	ematory or other place	1000.	20c. L	ocation - City or T	own, State	
<u>=</u>	permit. Page Department Important: if any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		Memorial Par	2003			e, Florida	
Ba	Depa Impo any is		(inchew)	ole 5	00 Univer	ss ජ්ලිව් ^{ly} ins Fu sity Blvd,	W, Silve	ome Inc. er Spring	, MD 20901	
П			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not en ach line.	nter the mode of dying	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death	
14.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	or as a consequence of):	ic enc	2/11/9/10/	bath			
	Examiner		Due to (
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):	12.0 - 1	/	ase	1.0		
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c.	or as a consequence of):	cara,	omyof	arn	<i>y</i>		
8760,	ate be executed hysician and the burial-transit		Bue to (
687	ate hy:	edical	d							
Вох	eath certifi attending for use as	an/M	23b. Was decedent pregnant	come of pregnancy wirth 2 Fetal death 3	☐Ectopic pregnancy			23d. Date of deliv	1	
о С	e deat	Physician/Me		ant at time of death 5	Other (specify)			Month	Day Year	
Р. О.	that the de led by the a detached f		Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
ds	puires tha n signed uld be det	Completed by	End stage ref	ral dis	sease		1 ☐ Yes	NO 3□Pro	No 3 Probably 4 □Unknown	
000	aw requir s been si 2 should l	plete	Hyper tensi	2 ク			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of	
<u>~</u>	The I	Com					performed? 1 Yes 2 N	death?		
/ita	ician: Sertific Sector,	Be	25. Was case referred to medical examiner? Hospital:		ent 3 DOA Othe	26. Place of Death (Co				
of	Physic r this cral dir	- To	27. Manner of Death 28a. Date of	npatient 2 ER/Outpatie	SIII JU DON	4 Transing Home	5 Residence Describe how inju		ify)	
on	nding ath. r: Afte e fune	atlor	1 Accident investigation (Mont	th, Day Year) Injury		k? Yes 2 □No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined 28e. Place building	of Injury - At home, farm, s ng, etc. (Specify)	treet, factory, office	28f.	Location (Street a City or Town, Sta	nd Number or Ru le)	ral Route Number,	
	spital ours a neral [29a. Certifier 1 Certifying Physician: To the	best of my knowledge, dea	ath occurred at the time	ne, date and place, and	due to the cause(s) and manner as	stated.	
	n 24 h	edical	(Check out) 2 Medical Evaminer: On the he	ania of avamination and/or i	Dunctigation in anno	ninion double convered a	t the time date at	d place and due	to the equec(e)	
	To the within 2.	ž	29b. Signature and title of certifier	7	29c. License	e number	29d. D	ate signed (Month	, Day, Year)	
•	140		Jan Min	<u>ν</u>	200	09543	29	12010	9	
	1		30. Name and address of person who completed caus Lriha Ruel		e, Print) OFORER T	Glentel.	Silvers	pring !	MD 20910	
	Sta	ate	31. Date filed (Month, Day, Year) 32.4	egistrar's Signature	Carte		/	4/		
1	Regist	rar	SEP 3 C 2005	meyer is fig						

		•	1 - For State Registrer	State of Mary		artment of F			iene 005	33361	
	Physici /Medic		Decedent's Name (First, Middle, Last) Joseph	F.	Bu	rke		2. Date of Deat Month Septemb	Day Yea	3. Time of Death 12:30 p M	
	Examir		4a. Facility Name (If not institution, give s	way		4b. Cily, Town, o			4c. County of De	^{ath} undel	
l.	Funeral Director		5. Social Security Number 578-07-5489 Usual Residence of Decedent	M 2□F 9	yrs. last birthday) O Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 1(irthplace (State or Foreign Country) 110	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tw. M.cdical Examiner must be notified at	Funeral Director	10a. State MD Anne Ar 10e. Street and Number 1775 Crofton Park 11. Marital Status	undel way	Crofton	10f. Zip Code	1114 lispanic Origin? (S		0g. Citizen of What 0	10d. Inside City Limits 1 □ Yes 2 ★ No Country?	
21215-0036	be filed within 72 hours after of tal Hygiene. d other then "netural", or Itel event, Ite W. Joal Examiner	Completed by Fur	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2		16a. Dece (Give	If Yes, specify Cuba □ Yes 2 No dent's Usual Occup kind of work done DO NOT use retired onal Mana	Specify: nation during most of world)			f Business/Industry	
Maryland 2	be filed ital Hygi id othar evant, I	To Be Co	17. Father's Name (First, Middle, Last) Joseph Thomas Bur				18. Mother's Nar Ellen		Maiden Surname)		
	D = C =		Joseph T. Burke	I (Son)	1	Kyle Road		ville, M	City or Town, State 21032 20c. Location - City of		
Baltimore,	Pages ent of nt: If i		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	emoval from State	cemetery, crer letro Cre	natory or other plac	9-2:		Baltimore		
Ba	permit. Popartm Importal any injura		23a. Part1. Enter the disease, or compli		. 1	Hardest 12 Ridg	y Funera: ely Avent		olis, MD	21401 Approximate	
Name of Street	Physician /Medical Examiner	ner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying	Due to (or as a co	ns of ence of):	Hear				Interval Batwaen Onset and Death 5975	
Box 68760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	an/Medicai Examiner	Lauss (Disease of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a co	regnancy	⊒Ectopic pregnancy			23d. Date of d	,	
P.O. B	at the deal I by the att etached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify)		an- Pidas	Month	Day Year	
Records, I	w requires that been signed t should be det	by	Part II. Other significant conditions con Myelo dys,	ntributing to death but no plasing sufficie		nderlying cause giv	en in Part I.	23e. Did tob	s 2 ⊠No 3 □	to the cause of death? Probably 4 Unknown aulopsy findings available	
Vital Re		Be Completed	Coustro in test. 25. Was case referred to medical examiner?	nal Ble	Oding		26. Place of Dea	autops	y prior to death?	completion of cause of	
of	Phya rathis	2	1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	y at		nnce 6 Other (Sp ow injury occurred	pecify)	
Division	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town	, State)	Rural Route Number,	
	To the Hospital or A within 24 hours after To tha Funaral Dirac completely filled in by	Medical	(Check only 2 Medical Exami	sicien: To the best of more: On the basis of example manner stated.		vestigation, in my o	pinion, death occu	rred at the time, da	ate and place, and di	ue to the cause(s)	
)	viti To CO	ec	29b. Signature and title of certifier	4		29c. Licens	931607		9d. Date signed (Mo.	ntn. Day, Year)	
_			George Cavanage	mpleted cause of death	Item 23a) (Type.	chelville.	RO B	owie, M	9/23/	,	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 8 2	32. Redistrar's	Signature	Sports					

				1- For State of Maryland / Department of Health Certificate of Death	n and Me th	ental Hy	giene Reg. No.	005	333	62
		Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day	Year	3. Time of	Death
		/Medic	al	Blanche Marilyn Baldwin		Month 09/27/			2:25	AM
		Examin	er	4a. Facility Name (If not institution, give street and number) Gilchrist Center Baltimore	on of Death		4c. C	County of Deal	h	
10	197	Funeral	357	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	ler 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State o	r Foreian
0		Director		073-28-4536	s Min.	(Month, Da 05/06/	1935	New	hplace (State of untry) York	
27,2005		pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside Cit	. Limita
27	2	Aanyla I sho	ō						1 🗀 Yes	
21	3	death with the Maryland ms 23a or 28a-1 show Intual tes notified at	Directo	Maryland Howard Elkridge 109. Street and Number 109. Zip Code			10g. Citize	en of What Co	untry?	
d v	1	h with		6410 Koffel Court 21075			USA		,	
ぎ		deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C Armed Forces? 15. Was Decedent of Hispanic C If Yes, specify Cuban, Mexico	Origin? (Spec	offy Yes or No	- 14	I. Race - Ame Black, Whit		
September	36	s after		1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ XNo If Yes, Give 1 ☐ Yes 2 ☐ XNo Specifi		110011, 010.)		Specify:		
	5-0036	tural'	ed by	3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation				Wh:		
=	15	n "na	plet	(Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during mo	ost of workin	g	100. Kind	1 01 Business/	industry	
DK	212	giene giene er the	Completed	12 Home Maker			Own	Home		
4	nd	be file tal Hy d oth	Be			(First, Middle,				4
BALDWIN	altimore, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	J.			nevieve				
10	Mai	d 2 sh th and th and ?7 is n traun		19a. Informant's Name/Relationship (Type, Print) Ellen M. Mackey/ Daughter 4273 Coattail Cou						
BLANCHE	ō,	s 1 and 1 Heal		20a Method of Disposition (20b. Place of Disposition (Name of		ite		ation - City or		
Ą	E O	Page nent o nt: If iry or		1 ÅBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) **Cemetery, crematory or other place) Pine Lawn Memorial Park & Cemetery	10/01	/2005	Farm	ington	NV	
3	alti	rmit. spartm porta y inju		21. Signature of Funeral Service See 22. Name and Address of Fact	cility Robe	ert E.	Evan	s Fune	al Home	2
d	<u> </u>	89 = 58		16000 Annapoli				D 20715	5	
	г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or	respiratory ar	rrest,		Approximate Interval Betw Onset and D	veen
	Ping.	Physician (Medical		Immediate Cause (Final disease or condition resulting in death) a. LVNg Canneer		-			mont	15
		/Medical Examiner		Due to (or as a donsequence of):						
	100		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
		outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
	0,	e exer		resulting in death) Last Due to (or as a consequence of):						
	8760,	cate by	Physician/Medical	d						
	9 ×	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy						
	Вох	atten after u	cian	in the past 12 months?			23	d. Date of deli Month	•	ear
	P.O.	t the d by the ached	hysi	1 ☐ Yes 2 Mo 9 ☐ Unknown 9 ☐ Unknown						
	S, P	ss thar gned I	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.	23e. Did to	obacco use	contribute to	the cause of de	ath?
	brd	equire				101	/es 2 □	No 3∏Pr	obably 4 XU	nknown
	ec	law ras be	Completed			24a. Was autop	SV	24b. Were au	topsy findings a ompletion of ca	vailable use of
	E H	: The					rmed? 2 No	death? 1 🗌 Yes	2 🗆 No	
	Vita	sician certifi rector	o Be	Hamital:		(Check only o			10 -	
	of	Phys or this oral di	-	27. Manner of Death 28a. Date of Injury 28b, Time of 28c, Injury at		e 5 🗆 Resid	/-	Other (Spec	INN VUSPI	CP
	ion	nding sth. r: Afte e funé	ation:	1 Month, Day Year) Injury Work? 2 Accident investigation (Month, Day Year) Injury Work? 1 □ Yes 2 □			,,,,,			
	Division of Vital Records,	r Atte er deg recto	Certifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (5 City or Tow		Number or Ru	ral Route Numb	oer,
	O	ital or raft ral Di	Cer							
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date a construction of examination and/or investigation, in my opinion, de and manner stated.	and place, an eath occurred	nd due to the d d at the time, d	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	
		To the within To the comple	Me	29b. Signarure and title of certifier 29c. License number				signed (Month		
				Mallum D58	303		Stat	anlass	272	005
``				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The find (Month Day Year) 23. Part find (Month Day Year)	0,			/		1
				31. Date filed (Month, Day, Year) 32. He strar's Signature	is st	102	N5U/	NO	5150	7
		Sta Registr		SEP 2 8 2005					,	

			1 - State of Maryla		artment of Heartificate of De			ne 2005	33363
*	Physici		1. Decedent's Name (First, Middle, Last) Sarah Elizabeth Buckler				2. Date of Death Sept 29		3. Time of Death 705 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Lo	Spring		4c. County of Dea Montgon	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 1 1 M 2 1 5 6 5	rs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir Ma	thplace (State or Foreign Pryland
	Maryland f ehow	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert 10c.	City, Town or Lo	ce Freder	ick			10d. fnside City Limits 1 ☐ Yes 2 ☐ No
	a or 28a-	i Director	10e. Street and Number Emmanuel Church Road		10f. Zip Code 20678		un Un	Citizen of What Co	ountry? Lates
336	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or Iteme 23a or 28a-f ehow event, the Medical Enatrinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp. If Yes, specify Cuban, 1 Yes 2 No	anic Origin? (Spe Mexican, Puerto Specify:	ecty Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	within 72 horelene. then "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give	dent's Usual Occupation is kind of work done during DO NOT use retired)	on ing most of worki	ng	oublic S	
and 2	id be filed with ental Hygiene ked other the ic event, the	To Be Co	17. Father's Name (First, Middle, Last) Stewart Chester Buckler	100		8. Mother's Name Eliza	e (First, Middle, Mail abeth Bu	den Sumame)	
	l and 2 should be fleatth and Mental I im 27 is marked of the treumatic eve	J	19a. Informant's Name/Relationship (Type, Print) Margaret McCarthy- sister	: 8 ¹⁹⁶ 1 ^{M3ilii}	Paddock	Lane P	otomac. N	ÎD′ [™] 270 8°5′4	Zip Code)
altimore,	of F f Ite		4 Mg ist a Domestic a Domestic Com	o. Place of Dispo cemetery, crei nmanue]	osition (Name of matory or other place) L Cemeter	yOct 1	2005 Hun	Location - City or tingtown	Town, State Maryland
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee		2. Name and Address of 405 Broomes		Rausch Fu . Port Re		
	Physician		23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			such as cardiac c	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consistence of the conditions) Sequentially list conditions,	ia					7 days
oʻ,	cate be executed physicien and the burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consumption of the cause of the cause) C. OVARIAN CAUSE Due to (or as a consumption of the cause)	ncer					8 weeks
68760,	certificate be nding physici use as the bu	Aedical	d						
O. Box	death e atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	etaf death 3[☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
٥.	luires that t n signed by uld be deta	Ď	Part II. Other significant conditions contributing to death but not ovarian cancer	resulting in the u	inderlying cause given	in Part I.	23e. Did tobac	_/	o the cause of death?
Reco	: The law requires that the cate has been signed by th page 2 should be detache	Completed					24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		2	6. Place of Death	(Check only one)		
Division of Vital Records,	ding Phys After this funeral di	10	1 Yes 2 No Hospital: Impatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o	of 28c. fnjury at Work?		me 5 Residence 28d. Describe how i		cify)
Divisi	in Bit of	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, sti ecify)			28f. Location (Stree City or Town, S		ural Route Number,
	of 4 7 y	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the time, investigation, in my opin	date and place, a ion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
)	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License n	10mber 1595	S 29d.	Date signed (Mont	h, Dey, Year)
	12		30. Name and address of person was empleted cause of death (in Jeffrey Lin MD 2150 Pennsylva		Print) NW Washing	aton DC	20037		
1 6 4	Sta Regist		31. Date filed (Month, Day, Year) 32. Registres Si	gnature &	Soule				

			For State Registrar	State of M	/larylan	d / Depa <i>Cei</i>	artment of H	lealth a Death	and Me	ental Hygie	en 2 0 0 5	33364
	Physicia	 an	Decedent's Name (First, Middle Selma	, Last) M•		ъ	l a alshuwa			2. Date of Death Month	Day Year	
	/Medić Examin	al:	4a. Facility Name (If not institution,		r)	D	lackburn 4b. City, Town, o	r Location of		Septembe	28 , 20 (4c. County of De	05 4:10P. M
	■xamin	er	Renaissance Gardens			<u> </u>	Silver				Prince (
	Funeral Director		5. Social Security Number 578–05–1516	6. Sex 7. A 1 ☐ M 2 ☑ F	Age (In yrs. 8	ast birthday) 7 Yrs.	If Under 1 Year Months Days	If Under Hours		B. Date of Birth (Month, Day, Y July8, 19	9. Bi	orthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Maryl.	tor	Maryland Monto	gomery		Silve	r Spring					1 ☐ Yes 2√ No
	with the 3a or 28a	I Direc	10e. Street and Number 3112 Gracefield	d Road, #50	3		10f. Zip Code	20904		10g	Citizen of What C United S	,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show apportant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show appropriately injury og other traumatic avant, the Madical Exertification once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Nidowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 1/4 Yes, Give Year or Dates	s?]No	i	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Ori an, Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Arr Black, Wh Specify: W	
Maryland 21215-0036	nin 72 ho n "natur Madical I	Completed	15. Decedent (Specify only highes		(54)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during mos	t of working	7	b. Kind of Busines	s/Industry
212	ed with ygiene yer tha	Com	Elementary/Secondary (0-12)			Book	keeper				private	
/land	uld be fill Mental Hy irkad oth	To Be	17. Father's Name (First, Middle, L Edwin	_{-ast)} Fre	У			18. Mothe Ethe	,	First, Middle, Ma	,	rlon
	nd 2 sho aith and I 27 is ma ir trauma		19a. Informant's Name/Relationsh Linda Dorr -Exec								City or Town, State, n, Maryla	
nore,	ages 1 a nt of Hez :: If itam / ocothe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		, a	emetery, crer	sition (Name of natory or other place Coln Ceme	, ,	Dai		c. Location - City o	r Town, State Maryland
Baltimore,	permit. P. Separtme mportant iny injury		4 □ Donation 5 □ Other (Scale) 21. Signature of Funeral Service I	278	10	D22	Name and Addre	ss of Facilit	ardt	Funeral	Home Di	_
	402 64		23a. Part1. Enter the disease, or	complications that caus	ed the death	77.	FOW FOWDE	T IAITT	I ROa	a Bertst	zile, Ma	ryland20705 Approximate
	Physician		shock, or heart failure. List of the failure is the	a. Intern	al Her		ge					Interval Between Onset and Death 2 days
۱	/Medical Examiner		AM 153000000 1000	Due to (or a Thromb	ocytoj	uence of): penia						5 days
	uted d ansit	Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a consequence herapy							2 weeks
,0928	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a Hodgki	ns Lyr	,						2 weeks
.O. Box 68	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	I death 3	Ectopic pregnancy Other (specify)			- University	23d. Date of de Month	elivery Day Year
S, D	se ign	by	Part II. Other significant condition	ns contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.		23e. Did toba		to the cause of death?
Vital Record	The law ate has b page 2 sl	Completed								24a. Was an autopsy performe 1 ☐ Yes 2∑	d? prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			. 3 DOA Cth	or		Check only one)		
of		on: To	1 ☐ Yes 2 ☒No 27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of In	iury	ER/Outpatien 28b. Time of Injury	IL SEL DOX	2/L INU		d. Describe how	ce 6 ⊡Other (Speinjury occurred	ecify)
Division	or Attan ifter deal Director: in by the	ertification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	ation ot be 28e. Place of I	Injury - At ho etc. (Specify	ome, farm, str	M 1 eet, factory, office	Yes 2□		f. Location (Stree City or Town,		Route Number,
_	Hospital 4 hours : Funaral ely filled	edical Ce	29a. Certifier 1 Certifyin (Check only one) 2 Medical i	g Physicien: To the bes Exeminer: On the basis and manner	of examina	wledge, death	n occurred at the time vestigation, in my o	ne, date an pinion, dea	d place, an th occurred	d due to the caus	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	To tha Hos within 24 h To tha Fur completely	Mec	29b. Signature and title of certifier	/. 1/-	310100.		29c Licens	e number		29d	. Date signed (Mon	th, Day, Year)
1	70		* TAlla)	Methett			1)00	433	75	1	7/29/2	5
			30. Name and address of person							/	//	
		•	Karen Merritt, 31. Date filed (Month, Day, Year)		Gracei strar's Signa		Road Silv	er Sp	ring,	Marylar	nd 20904	
**	Sta Registr		SEP 30	2005		4. Agos						

Funeral

r then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

filed within 72 hours after death with the Maryland Pagas 1 and 2 should be nent of Health and Mental nt: If item 27 is marked o permit. Paga Department o Important: If any injury or once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036 The law requires that the death certificate be executed attending physician for use as the buria the signed by t d be detach To the Hospital or Attending Physician: To the Funeral Director: After th completely filled in by the funeral within 24 hours a

Division of Vital Records, P.O. Box 68760, 4

Certificate of Death Reg. No. 3. Time of Death Oct 5, 2005 4:39.pm 4c. County of Death Allegany 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 18, Birthplace (State or Foreign Counts) Social Security Number Months Days Hours 212-10-0102 96 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits Cumberland MD Allegany Director Y☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 30 Potomac Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes Z No Specify: ģ Specify white 3 ☐ Widowed X ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence (Willard) Brant Bertie Andrew Brant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 30 Potomac Street Cumberland MD 21502 Mary Poling cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/2005 Hillcrest Memorial Park Cumberland MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? PELEQSEA 1 XYes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Attesidence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOC17565 Bot. 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

3

State

AJ Ballino

OCT 1 4 2005

31. Date filed (Month, Day, Year)

922 N241

. Registrar's Signature

62 6218

21562

State of Maryland / Department of Health and Mental Hygiene 0 05

			State of Mar	yland / Depa <i>Cer</i>	rtment of H	lealth and <i>Death</i>		ene2 ()	05	33366
		1. Decedent's Name (First, Middle, Las	it)				2. Dete of Deeth			3. Time of Death
	Physician	Robert Spencer ('osens				Scot.	Dey 2	Year Oo 5	6:30 AN
	/Medical Examiner	4e Facility Name (If not institution, give				4b. City, Town, o	Location of Deeth	4c. County		+ 30
	LXammer	926 Mulberry St.				Had	gerstown	Washi	naton	County
	Funeral	5. Social Security Number 6. Sec	ex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr				ace (Stete or Foreign
	Director	219–20–0469	XM 2□F	79 Yrs.	Months Deys	Hours Mir	s. 8. Date of Birth (Month, Day, Sept 25	1926	Mary	land
	P .	Usuel Residence of Decedent								
	arylar allow	10a. Stete 10b. County		Oc. City, Town or Loc					10	od. Inside City Limits X□ Yes 2□ No
	with the Meryland or 28s-f show be notified at Director	Maryland Washing	ton	Hage	rstown					
	vith the sound of	10e. Street end Number			10f. Zip Code		10	g. Citizen of V	What Count	ry?
	r tems 23a ciner must tems 15a ciner must temps 15a ciner must temps 15a cineral (926 Mulberry St.				21742		nited		
	ter des	11. Maritel Status	12. Was Decedent Even Armed Forces?	11/20/45	Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - America ck, White, e	
20	urs eff	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11/20/45 ["] 12/4/46	☐ Yes X☐ No	Specify:		Specify	/: Wh	ite
21215-0020	n 72 hours efter death with the Menyland "natural", or flems 23a or 28a-f show idical Examiner must be inclifted at leted by Funeral Director	15. Decedent's Ed		16a. Deced	ent's Usual Occup	ation	1	6b. Kind of Bu	usiness/Indi	ustry
715		(Specify onfy highest grade Elementary/Secondary (0-12)	de completed)	(Give F	rind of work done O NOT use retire	during most of we	orking			,
7	d within giene.	12	College (1-4or 5+)	Dis	patcher			Oil C	ompan	У
	tal Hyg d othe event,	17. Fether's Neme (First, Middle, Last)			Farance	18. Mother's Na	ame (First, Middle, M	aiden Sumam	7e)	
lar	Menta Menta arked artic en To E		.Jr.			Dorot	hv Hibber	t Cose	ns	
Maryland	and h	19a. Informant's Name/Relationship (7		19b. Mailing	g Address (Street		Rurel Route Number,			Code)
	and 2 waith e	Thomas S. Cosens	(son)	4809	Briarhi	11 Rd. N	lew Bern.	North (Carol	ina 28562
ore	Of He	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domoval from State	20b. Place of Dispos cemetery, crem	ition (Name of atory or other place	J o)	lew Bern, Date 2			
Ë	Peges nent of ant: if h	4 □ Donation 5 □ Other (Specify		Rest Have	n Cemete	ry	10/3/05 H	agerst	own Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filled within Depertment of Health and Mental Hygiene. Important: if Item 27 is merked other than any injury or other traumatic event, the Mannes. To Be Compi	21. Signature of Funeral Service Licen	see	22.	Name and Addre	ss of Facility	ouglas A.	Fiery	Fune	ral Home
Œ	20 = 20	1 Villolos-	NIII	12	31 Faste		_	_		
		23a. Part1. Enter the diseese, or composhock, or heart failure. List only of	dications that caused the	deeth. Do not ente	r the mode of dyir	ng, such es cardia	N. Hager:	SCOWII_I st,	1 1	Approximate Interval Between
The same of	Physician	SHOOK, OF HOUR LESS ONLY	one cadsejon decir line.							Onset and Death
18	/Medical	Immediate Cause (Final disease or condition	- CL	rolangio	Carri	homa				TUC
	Examiner	resulting in death)	Du Du	e to (or as a consequ	ience of):	7.104]	1 / / /
	in st d		h						i	
	icete be executed physician and s the burlal-transit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	Du	e to (or as a consequ	ience of):					
58760,	cete be execu physician and the burlal-trai	Cause (Disease or injury	c							
387	physicia s the bur	that initiated events resulting in death) Last	Du	e to (or as a consequ	ence of):				į	
	es thet the death certific igned by the attending purple deteched for use as by Physician/Me		d							
Вох	net the death certif d by the attending leteched for use a Physician/Me	D. A. H. OAb T Lift A Albi		A second	4-4-4	- C. B. Al	OOL BILLL			4 15 16
P.O.	y the sched	Part II. Other significant conditione co	ntributing to death but r	not resulting in the un-	denying cause giv	en in Part I.	1 Tyes	/		the cause of death?
	es thet igned b be dete						1 10 10	2/□ NO	3 Probe	ibly 4 Onkilowii
Records,	requires that the seen signed by the hould be deteche eteche						24a. Wes an	autopsy		e autopsy findings
Ö	The law require sete hes been signed a should in Completed						perlormo	ed?	com	lable prior to apletion of cause eath?
Re	sician: The law is certificate hes birector, page 2 st						1C Yes	2010		Yes 2 No
	ysician: The I s certificate he director, pege	25. Was case referred to medical				26 Place of Do	eath (Check only one		-	Tes 20140
of Vital	Physician: this certific rel director,	evaminer?	Hospital:	2 ER/Outpatient	3 DOA Oth	or:	Home 5 Residen		er (Specify)	200
ō		27. Menner of Death	28a. Date of Injury (Month, Day Y		28c. Injur Wor		28d. Describe how			
on	oding I th. : After e funer	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury		Yes 2∐No				
Division	I or Attending effer death. Director: After d in by the fune ertification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre	et, factory, office		28f. Location (Stre		er or Rural	Route Number,
ā	tal or Attending P rs efter death. al Director: After ti led in by the funere Certification;	4 Hornidge	building, etc. (<i>эреспу)</i>			City of Yown,	Siale)		
	ospit hour unera siy fills	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of niner: On the basis of ex	ny knowledge, death	occurred at the tin	ne, date and plac	e, and due to the cau	se(s) and ma	nner as sta	ted.
	To the Hospital or Attending Physician 24 hours defer death, completely filled in by the funeral ompletely filled in by the funeral Medical Certification: 1	one)	and manner stated	i.	,					
	T S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier	2 1		29c. Licens		290	d. Date signed		
É	1510H	Muchael 1.	Milova	1 MO		11667		10.2	2.01	
	10+10	30. Neme and address of person who c			rint)	1 0	(anyou	11	,	
		31. Date filed (Month, Day, Year)	1 Co Mai		10 /h	edical	(inpopul	1/25	13,77 /00	un MO
	State	OCT 0.3 201	75 Sz. Jegistrer's	Ligitature A	. A.D. 1					

DHMH 16 Rev 6/95

			For State of Maryland		tment of H			giene	(1111)	33367
\mathbb{S}^{d}	3	<i>#</i> -	Decedent's Name (First, Middle, Last)				2. Date of De	aath		3. Time of Death
	Physici		MERCEDES CUARESMA-RICH	IARD			Sept	28, Day	2005	15:00 M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat			County of Dea	
k			Shady Grove Adventist Hosp	pital	Rock	ville			MOntg	omery
F	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av Year		
п	Director	Ŷ.	631-38-8374 ^{1□M 2} 90	Yrs.	INOTHINS Days	TIOUTS NITT.	Sept2	8,19	915	rthplace (State or Foreign ountry) Africi Guinea
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	. Town or Loca	ation					10d. Inside City Limits
	Maryli eho	ŏ								12 Yes 2 No
	28a-	Director	MD Montgomery 10e. Street and Number	Rockv	111E 10f. Zip Code			10g Cit	izen of What C	oustry?
	with Se or	I DII	2022 Baltimore Rd # L-21		2085	1				ountry :
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	3. 13. W			pecify Yes or No		pain 14. Race - Am	encan Indian
(0	ifter o	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		as Decedent of His res, specify Cubar				Black, Whi	te, etc.
93	eli, o	by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 5	¥Yes 2□ No	Specify: G	uinea		Specify: B	lack
2-0	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "netural", or items 23s or 28s-f show event, the Medical Exerciper must be notilised at	Completed	15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupa nd of work done do		rkina	16b. Ki	ind of Business	s/Industry
2	ithin .	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DC	NOT use retired)	anny most or wor	Kiilig		Priv	2+0
2	ygier ygier t,		12th		Seamstr					
and	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other then "netural", or items 23s or 28s-f show sumatic event, the Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				me (First, Middle			
2	J Mer J Mer nark	To	Rufino Cuaresma				ernice			
Ma	d 2 st th and 7 Isr		^{19a.} Informant's Name/Relationship <i>(Type, Print)</i> Daughter Mercedes Cabrera—Cuaresma							
ė,	1 an Heall em 2		20a. Mathod of Disposition 20b. Pla	ace of Disposit	tion (Name of		#L-21 Date	ROCK	cville	MD 20851
0	de in age		Burial 2 Cremation 3 Removal from State	metelp crema	tory or other place					
Baltimore, Maryland 21215-0036	artme ortan		4 Donation 5 Other (Specify) Ga 21. Signature Funeral Service Licensee		Heaven					oring, MD Home PA
Ba	permit. Pages 1 and 2 should be Department of Health and Menta important; if Item 27 Is marked eny injury or other traumatic events.		Jena Klimin	1 / 1/						,MD20850
17	, ** ×9		23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. Ust only one cause on each line.							Approximate
r	Physician		Immediate Cause (Final	1//	101					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Ven triculor Due to (or as a consequence)	7760//	07107					
	Examiner		Distance	whom!	no the					
L,	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):	uparry					
	cuted nd ransi	Examiner	that initiated events							
Ö,	e exe	EX	resulting in death) Last Due to (or as a consequence)	ence of):						
8760,	icate be executed physicien and s the burial-fransit	dical	d							
9	leath certific aftending p I for use as	Med	IF FEMALE:							
Вох	ath c aftend for us	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1	death 3 □Ed	ctopic pregnancy			2	23d. Date of de Month	livery Day Year
o.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown 9 ☐ Unknown	ath 5∐C	Other (specify)					,
۵.	that fed by	H	Part II. Other significant conditions contributing to death but not result	Iting in the und	erlving cause giver	n in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
ds	uires tha signed Id be del	d by	Chance Os butter Lux Disease				10	Yes 2	ZNo 3□P	robably 4 Unknown
Ö	w require been sig should b	lete	9 01000				24a. Was		24h Wasa	
Be	he far e has ige 2	Completed					autor	osy rmed2	prior to death?	utopsy findings available completion of cause of
Division of Vital Records, P.	ifficate or. pa	ပိ	25. Was case referred to medical			OC Place of Page	1 ☐ Yes	2 No	1 ☐ Yes	2 1 No
>	ysician; The lavis certificate has director, page 2	ToB	examiner?	R/Outpatient	3□ DOA Other		ome 5□ Resid		COthor (Soc	10(64)
ō	g Phys er this ieral di		27. Manner of Death 28a. Date of Injury 2	28b. Time of	28c. Injury Work		28d. Describe t			City)
0	ttendin death. ctor: Afr y the fur	atlo	2 Accident investigation	Injury		es 2 🗆 No				
<u>\S</u>	l or Attencafter death Director: In by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At hom building, etc. (Specify)	ne, farm, street	t, factory, office		28f. Location (S City or Tox	Street and	d Number or R	ural Route Number,
	ital o rrs aft ral Di led ir									
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only open control of the basis of examination of the basis of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of the basis of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the	rledge, death or on and/or inves	ccurred at the time	e, date and place nion, death occu	, and due to the rred at the time.	cause(s) date and	and manner as	s stated. e to the cause(s)
	thin 2 the mplet	Med								
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	3	}	20 Marshall Torry	220) (7:- 5:	- J GC/.	30 7		cp ren	wher 29	, aus
			30 Name and address of person who completed cause of death (Item: Done 1 J. Goldberg 6/16 Executive	Q/	Rock	, the mo	208	53		
38.6	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	не Лапа	29c. License 0 2 / . Int) Rock					
	Registr		OCT 0 3 2005 10 1000 100	· Marian						

			1 - For State Registrer	State of M	laryland / Dep <i>Ce</i>	ertificate of			piene 005	33368
	Physici	an	1. Decedent's Name (First, Middle, L.	,				2. Date of Dea Month	Day Year	3. Time of Death
	/Medi Examir		Christine H. Cho		r)	4b. City, Town, o	or Location of Deatl		dc. County of Dea	
	LXaiiii	içi	Montgomery Hospi	.ce- Casey	House	Rock	ville		Monto	jomery
	Funeral			Sex 7. A 1 □ M 2 😾 F	ge (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bir	thplace (State or Foreign ountry)
	Director		577-44-5924 Usual Residence of Decedent		94			Sept. 1	2, 1911 F	oland
	irylanc show	_	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	he Ma	ecto	Maryland Montgo	mery	Take	oma Park			(110	1 Tyes 2 No
	a or 3	Dir	7901 Cole Avenu	ıe		10f. Zip Code 20912		1	Og. Citizen of What Co USA	ountry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minipury or other traumatic event, the Medical Exam artifust is instiffed at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	¥No	Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
215-0036	ithin 72 h ne. nan "natu	Completed by	15. Decedent's 8 (Specify only highest g	ade completed) College (1-4o	(Giv 15+)	edent's Usual Occup e kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business	Andustry
121	Hygier Hygier ther th	S	17. Father's Name (First, Middle, Las	2	Ca	shier	18 Mother's Nar	ne (First, Middle, i	Food	
ano	ld be fental I	To Be	Joseph Kolenda					Kolendo	vialacti Sarriamo,	
Maryland	nd 2 shou Ith and M 27 is mar	-	19a. Informant's Name/Relationship Zbigniew H. Fedo			-			, City or Town, State, 2 , MD 20912	
Baltimore,	Pages 1 au ent of Hea nt: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from Stat	8 -	ematory or other pla		ober 4,	20c. Location - City or	Town, State
Baltin	permit. P Departm Importar any inju		21. Signature of Funeral Service Lice		Í	22. Name and Addre	ss of Facility Collins	Funeral	Home Inc	g, MD 20901
	Physician /Medical		23a. Part1. Inter the disease, or conshock, heart failure. List on Immediate Cause (Final disease or condition resulting in death)	one cause on each	d the death. Do not e	nter the mode of dyir	ng, such as cardiad			Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to the law speed by the attending physician and be detached for use as the burial-transit in the law is the burial-transit in the law is the burial-transit in the law is the burial-transit in the law is the burial-transit in the law is the l	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. It is to be derying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of): s a consequence of):					
.O. Box 6	the death certifically the attending place of the astending place of the astending place as the astending place of	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		23d. Date of del Month	livery Day Year
rds, P.	quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	ven in Part I.		pacco use contribute to es 2 ☑ No 3 ☐ Pr	o the cause of death?
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Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Manital		Lou		th (Check only on	e)	
of	ding Phys n. After this funeral di	tlon; To	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	tient 2 ☐ ER/Outpatie jury 28b. Time lay Year) Injury	of 28c. Injur Wor	ry at		ence 6 © Other (Specow injury occurred	eify)Hospice
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attel completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not determine	28e. Place of !	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) Certifying F	hysician: To the bes miner: On the basis and manner:	it of my knowledge, dea of examination and/or i stated.	th occurred at the tir nvestigation, in my o	me, date and place opinion, death occu	, and due to the carred at the time, do	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	within To #	×	29b. Signature and title of emiffice	2011	,	29c. Licens	se number	_ 2	9d. Date signed (Monti	Day, Year)
	24		CARA	n		- 0"	11248	5	4/50/	H
			30. Name and address of person who Charles Harriso				Road, Roc	kville, l	MD 20855	•
	Sta Regist		31. Date filed (Month, Day, Year) OCT 0 3 20	32. Regis	trar's Signature	uli)				

			1 - State Registrer	State of Maryland		rtment of Health a	and Mer	ntal Hygien	GUUN	333	69
	Physici /Medic		1. Decedent's Narry (First, Middle, Last)	Clai			2.	Date of Death Month	300°5°	3. Time of 2 15	Death A M
	Examir		4a. Facility Name (If not institution, give str	1 - 0	n Rd	4b. City, Town, or Location o	of Death	41	County of Death	1	
	Funeral Director			7. Age (În yrs. la 90	est birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Min. J.	Date of Birth (Month, Day, Year ULY 1, 1	9. Birth	place (State or intry) LLY	r Foreign
	death with the Maryland ms 23a or 28a-f show		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo					10d. Inside Cit	
	he Ma Sa-fs	Funeral Director	MD Howard	El	licot					1 ☐ Yes	24No
	with t a or 2	ä	10e. Street and Number 8375 F Montgomery R	un Poad		10f. Zip Code 21043			itizen of What Cou Jnited St		
	death ms 23	era		2. Was Decedent Ever in U.S		/as Decedent of Hispanic Orig	gin? (Specify	Yes or No-	14. Race - Amer	ican Indian,	
	be filed within 72 hours after death with the Maryla mail Hygiens and at the Maryla deher than "neturel" or itams 23a or 28a-f show event. Its Marical Examinet must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Yes, specify Cuban, Mexican ☐ Yes 🏖 No Specify:	i, Puerto Rici	an, etc.)	Black, White Specify:	, etc. Vhite	
3-003p	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	ent's Usual Occupation kind of work done during most	t of working	16b. i	Kind of Business/li		
7	within ine. than "	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. [OO NOT use retired)	•		O II		
N	filed y Hygie other f	ပိ	17. Father's Name (First, Middle, Last)		н	memaker 18. Mothe	r's Name (F	irst, Middle, Maide	Own Home n Sumame)	<u>}</u>	
Iana	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It e Ms	To B	Antonio Bellini			Anton	ia Bei	llini			
Mary	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Type			g Address (Street and Numbe				<i>'</i>	
a) S	1 and Health Bm 27 ther tr		Maria Mustillo/Daugi 20a. Method of Disposition			resh Ponds Roa	d East		.ck , NJ (.ocation - City or T		
	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	metery, cren	atory or other place) ss Burial Park	10/4		,		NT.T
	permit. Pages 1 and 2 Department of Health & Importent: If Item 27 is eny injury or other tra <u>2002</u> 9.		21. Signature of Funeral Service Licensee)44 22	Name and Address of Facility 12 Old Columb	Harry	H. Witzk	e's Fami	ly FH	Inc.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations the caused the death.					te crey,	Approximate Interval Betw	9
	Physician	ı	Immediate Cause (Final disease or condition	Muni	CNL	il Info	arcti	نس		Orset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a corr eque	ence of):	***	*				
	8	le.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	scuted nd transit	Examine	that initiated events C.								
8/00,	cate be executed physician and s the burial-transit	ai Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
200	ficate g phys	edicai	d.						_		
X	death certificate be executed e attending physician and d for use as the burial-transit	an/M	23b. was decedent pregnant	c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of deliv	. ,	
D	the dea y the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown		Other (specify)			Month	Day Y	'ear
ŗ.	n requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contr	ributing to death but not resul	fting in the ur	derlying cause given in Part I.		23e. Did tobacco	use contribute to	the cause of de	eath?
cords	faw requires that as been signed b 2 should be deta	ed b						1 ☐ Yes 2	!□No 3□Pro	babiy 4 📈	nknown
ပို	faw re nas be	ompieted						24a. Was an autopsy	24b. Were aut	opsy findings a ompletion of ca	vailable use of
	siclen: The law s certificate has b lirector, page 2 s	0						performed? 1☐ Yes 2\X\N	death? 1 ☐ Yes	2€] No	
VItal	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	spital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien			theck only one) 5 ☐ Residence	6 MOther (Space	(6.1	
100	ig Physical digestrated	-	27. Manner of Death		28b. Time of Injury	28c. Injury at Work?		. Describe how inju		19)	
SIO	tendir eath. or: Af the fur	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 Yes 2 N	-				
DIVISION	or Att after d Direct in by	ertification;	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre)	et, factory, office	28f.	Location (Street a City or Town, Star	nd Number or Rur e)	al Route Numb	er,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	cian: To the best of my know er: On the basis of examination	vledge, death ion and/or inv	occurred at the time, date and estigation, in my opinion, deat	d place, and th occurred a	due to the cause(sat the time, date ar	s) and manner as and due	stated. to the cause(s)	
	To the within Fo the comple	Med	29b. Signature and title of certifier	Two C		29c. License number		29d. D.	ate signed (Month,	Day, Year)	
			1			136786		9	-30-0	5	
r)	a2		30. Name and address of person who com	npleted cause of death (Item	23a) (Type, 1	29c. License number 27c 786 Print) Resslor	٤١,١	Glen 1	Druce 1	W. 20	060
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 3 200	32. Polistrar's Signatu	dre	arely					

occessor, Graps

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28 2005 **Physician** Month SEPTEMBER 2045 M Gladys Marie Collison /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TALBOI THE MEMORIAL HOSPITAL E ASTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√□ F Director 213-24-1676 Maryland August 8, 1928 Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Neutical Examinar must be notified at Director 1 ☐ Yes 2 TNo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25790 Burrsville United States of America
No- 14. Race - American Indian,
Black, White, etc. Funeral Road 21629 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John H. Shaffer <u>Carrie Hostetler</u> 19a. Informant's Name/Relationship (Type, Print) Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21629 permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra Martin E. Collison, 25790 Burrsville Road, Denton, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Denton Cemetery 10/2/2005 Denton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Juneral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician O varia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate any England to immediate any England to improve the conditions of the condition Due to (or as a consequence of) Examiner use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 lan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death Physici 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes ≥Q No 1 TYes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Lepatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 00053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields, M.D. 219 Soutr 219 South Washington Street, Easton, Maryland 21601 31. Date filed (Month, Day, Year) State Registrar 0

State of Maryland / Department of Health and Mental	Hygie
Certificate of Death	Rea

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) JOHN MICHAEL CUNNINGHAM SR.

2005

ŏ8,

2. Date of Death Month OCTOBER

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	333773 37377																
	ANNE ARUNDEL MEDICAL CENTER					ANNAPOLIS				AN	ANNE ARUNDEL						
	5. Social Security N	st birthday)	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year DEC • 06, 19														
	219 48 61	86	XX ^M 2□ F	5	6 Yrs.	Months Days	Hours	Min.	DFC. 0	6.194	8 WAS	Country) SHINGTON D.C					
-	Usual Residence of								DLO. 0	,	117.11	DILLINGION D.C					
-	10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits					
												1 ☐ Yes 2 ☐XN					
-	MARYLAND	ANNE A	RUNDEL	EDGE	WATER					1							
]	10e. Street and Nur	nber				10f. Zip Code				10g. Citi	zen of What	Country?					
	1652 BAY	RIDGE	ROAD			21037				דדמנו	UNITED STATES						
5	11. Marital Status		12. Was Decede			Vas Decedent of H						merican Indian,					
בחומו	1 🗆 Never Marri	ied 2□ Marrie	Armed Force d 1 ☐ Yes 2[1	f Yes, specify Cuba	ın, Mexican	n, Puerto Ri	can, etc.)		Black, W						
2	3 Widowed		If Yes, Give Year or Date	••		∏Yes 2∏XNo	Specify:				Specify: WI	utor					
		15. Decedent's		-	16a Donos	lent's Usual Occupa	otion										
Completed	(Spec		grade completed)		(Give	kind of work done o	during most	t of working	7	IOD. IX	nd of Busine	SSAIIGUSITY					
-	Elementary/Secon	ndary (0-12)	College (1-4d				,				MODIT	·					
	12		0		AUTO N	TECHANIC P					OMOBII	ഥ단					
	17. Father's Name ((First, Middle, La	ist)				18. Mothe	er's Name (First, Middle	e, Maiden	Sumame)						
	CLIFFORD	CUNNING	GHAM				EVA	KILL									
	19a. Informant's Na	ame/Relationship	o (Type, Print)		19b. Mailin	g Address (Street a		er or Rural	Poute Numi	ber, City or	r Town, State	e, Zip Code)					
Ŋ	או <i>ורי</i> ביד דא ד	TTIME	E /Darrer	ו כויטו													
1112	ANGELIA J 20a. Method of Disp		E (DAUGHT			SAY RIDGE sition (Name of	KOAD	Da Da			21037	or Town, State					
	· ·		☐Removal from Sta	1 000	netery, cren	natory or other plac	θ)	Da	.0	200. LO	Cation - City	or rown, State					
1	` 4 □Donation			KAL	AS CRE	MATORY	11	0-10-	05	EDGE	WATER	MD.					
	21. Signatur di Mu	nutral Service Lie	censee	5	22	. Name and Addres	s of Facility	y CEVD	CE D	KAT.A	S FINI	ERAL HOME					
ļ	> /////	IM				73 SOLOM						R.MD. 21037					
+	23a Part1 Enter th	ne disease or or	omplications that caus	ed the death							EVVAIE	Approximate					
	shock, or hear	rt failure. List or	nly one cause on each	line.	DO HOL BILL	or the mode of dynn	g, such as	Cardiac or	espiratory i	airesi,		Interval Between Onsetland Death					
	Immediate Cause (disease or condition			The	umon	ia						days					
resulting in death) a. Due to (or as a consequence of):												02.0					
	if any, leading to im	mediate	b. Due to (or a	as a conseque	ence of):		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	cause. Enter Unde				, .												
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	that initiated events	rtying injury	C. Due to far	20.2.0000000	nnon of/-												
	that initiated events resulting in death) L	rtying injury	c Due to (or a	as a conseque	ince of):												
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	that initiated events resulting in death) L	rtying irjury .ast	d. 23c. If yes, outcom	ne of pregnanc						2	d. Date of c	delivery					
	IF FEMALE: 23b. Was decedent in the past 12	trying injury ast pregnant months?	d	ne of pregnand 2 □ Fetal d	cy leath 3	Ectopic pregnancy				2	3d. Date of c	delivery Day Year					
	IF FEMALE: 23b. Was decedent	trying injury ast pregnant months?	d	ne of pregnand 2 □ Fetal d at time of dea	cy leath 3	Ectopic pregnancy				2							
nysicial medical	IF FEMALE: 23b. Was decedent in the past 12 1	pregnant months?	d	ne of pregnand 2 ☐ Fetal d at time of dea	cy leath 3 l	Other (specify)			20. 5		Month	Day Year					
n polonium mondo	IF FEMALE: 23b. Was decedent in the past 12 1	pregnant months?	d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	ne of pregnand 2 ☐ Fetal d at time of dea	cy leath 3 l	Other (specify)	en in Part I.		23ə. Did		Month	Day Year to the cause of death?					
Dy Filysicial Emedical	IF FEMALE: 23b. Was decedent in the past 12 1	pregnant months?	d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	ne of pregnand 2 ☐ Fetal d at time of dea	cy leath 3 l	Other (specify)	en in Part I.				Month se contribute	Day Year					
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Maryland / Department of Health and I	Mental Hyg	liene	22272
			Registrar Certificate of Death		eg. N2 0 0 5	33372
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
	/Medi	_	Mobert E. Cherrix Sr.		39-3005	3:50 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl	h	4c. County of Death	
			Hartley Hall Nursing Home Manual Comote Lity 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	I o Data of Right	Worcesto	
	Funeral Director		Months Days Hours Min.	(Month, Day,		3
	- 0.00		Usual Residence of Decedent	6-23-	-1991 Nice	Jinia
	yland		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Mar 9-f st	tor	VA Accomack Chincotcaque			1 AYes 2 No
	th the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cour	ntry?
	death with the Maryland rms 23s or 28e-f show	a	3533 Midge Mood 23336		U.SA.	
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	iurs after death with the Marylan elf, or Items 23a or 28e-f show Exantrer mart be rictiffed at	by Fu	1 Never Married 2 Married 1 Never State 1 Never Married 2 Never Married 1 Nev	,	Specify: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
00		d b	Year or Dates: Coast Coast		4011	
15	"na	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Ind	dustry
12	filed within Hygiene. Ither then "ont, the Median"	E O	Elementary/Secondary (0-12) College (1-4or 5+) Main tag nate		Fish and	Ma 11/2
D	be filed ntal Hyg sd other event,	BeC		ne (First, Middle, A		Wildlife
Maryland 21215-0036	should be filed within and Mental Hygiene. marked other then imatic event, the M	To B	Elva Cherrix Boena	Birch		
ary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		City or Town, State, Zip	Code)
	1 and 2 Health a em 27 is	h í	Lillie Cherrix 3533 Ridge Road C	hincolead	11/150	
J. C.			20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or To	wn, State
E	Page nent o		TLABurial 2 Ucremation 3 Unemoval from State	lalacos 1	Chincotrop	11 A
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Ficility	ajagos	Cimicons	VA 23336
m	88 28	GI 9	Umanda C. Betts Solver Fineral Home	6327 CI	nurch St. Cl	rincokague
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Cononary Angery Descase			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	LAdiminei	_	Sequentially list conditions, b.			
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mury)			
	be executed ician and burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,		dicai E				
687		0 1	d			
Вох	death certific e attending p id for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	rv
	0 0	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5 Other (specify)			Day Year
P.O.	that the death ed by the atter detached for	Physician/M	9 Unknown			
	requires that the een signed by the nould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
rd	v require been sig should b	edl	Phimowary namosis.	1 ☐ Ye	s 2 No 3 Prob	ably 4 Hinknown
of Vital Records,	as b	Completed	DIABETES MELLITUS.	24a. Was ar	24b. Were autor	osy findings available inpletion of cause of
Ä	0 5 0	E		perform	y prior to con death? 1 ☐ Yes	
ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner? 26. Place of Dea	th (Check only one		_
†	.s .ip	2		ome 5 Resider	nce 6 Other (Specify)
ū	ng fter	on:	27. Manner of Death 28a. Date of Injury 1 Divatural 5 ☐ Pending (Month, Day Year) 28b. Time of 28c. Injury at Injury Work?	28d. Describe hor	w injury occurred	
Sio	Attending r death. sctor: Atte	cati	2 Accident investigation 3 Suicide 6 Could not be			
Division	or At after of Direct in by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (Str. City or Town,	eet and Number or Rural , State)	Route Number,
	pitel		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	(-)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only one) Check only one Check one Check only one Check one Check only one Check only one Check only one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check on	red at the time, da	use(s) and manner as sta te and place, and due to	the cause(s)
	o thin o the complete or or or or or or or or or or or or or	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, L	Day, Year)
	- > P= ()		Say SharaD & SATYAL, MD 00062172		9/29/200	5.
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 - 1 /200	
H.	10+1		Sharad A. Satyal M.D. 1604 Market St. Poco	molie 1	ih Mn a	11851
**	Sta		31. Date filed (Month, Day, Year) 32. Megistrar's Signature		11	
5 0 .	Registr	ar	SEP 3 0 2005 Killer & Species			

			1 - State Registrer	of Maryland	d / Depa <i>Cei</i>	artment of I <i>tificate of</i>	lealth Death	and Mental	Hygien	2005	33373
	Physicis	212	Decedent's Name (First, Middle, Last)			,		2. Date of	Da	ay Year	3. Time of Death
	Physicia /Medic		Joy Valerie		rpente				ember	28,2005	
	Examin	er	4a. Fecility Name (If not institution, give street and Malcolm Grow Medical Co			4b. City, Town,		Force Bas		c. County of Deal	
	Funeral		Social Security Number	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Unde			rince Ge	thplace (State or Foreign
	Director		579–66–5827 1□ M 🛠 F	5	8 Yrs.	Months Days	Hours	Min. Sept	Birth Day Year 26,19	947 Lou	isiana
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho	tor	Maryland Prince George	s Fore	estvil	le					1 ☐ Yes 2X No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. C	ilizen of What Co	ountry?
	238 c	Funeral Director	7310 Mason Street				747			ited Sta	
	er de: ftems	nue	Armed	ecedent Ever in U.S Forces?	S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Specify Yes o an, Puerto Rican, etc.	r No-	14. Race - Ame Black, Whit	
336	al', or	by F	If Yes,	s 2](] No Giv <i>e</i> r Dates:		1□ Yes 2🛣 No	Specify	r:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Ithen "natural" or fems 23a or 28a-f show the Medical Examinar must be notitied at	sted	15. Decedent's Education (Specify only highest grade complete	d)	16a. Deced	lent's Usual Occu kind of work done	pation during mo	st of working	16b. I	Kind of Business/	/Industry
121	vithin ne. hen *	Completed		(1-4or 5+)	life. I	DO NOT use retire	id)		77-	- d1 C	
Q 7	be filed within 72 hours after death with the Marylar at Hydision. It Hydision. It has institutel, or flems 23a or 28a-1 show other than "natural," or flems 23a or 28a-1 show event, the Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)		Legar	Secreta		ner's Name (First, Mi			overnment
an	should be filed vand Mental Hygis amarked other t amaric event, III	To Be	Robert Maurice Whitting	ton, Sr.			Vir	ginia		Ernest	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumatic event, the Moce.		19a. Informant's Name/Relationship (Type, Print) James T. Gibbs —son					per or Rural Route No			
e, N	1 and Health sm 27 ther tr		20a. Method of Disposition	20b P		sition (Name of	reer .	Forestvil	-	Location - City or	
nor	ages ont of the		1 Burial 2 Cremation 3 Removal fro	m State CE	emetery, cren	natory or other pla				•	, Virginia
Baltimore,	mit. Partme		21. Signature of Funeral Service Licensee					ardt Fune			, virginia
<u> </u>	Pe di la la la la la la la la la la la la la		Worseld V, Bayes	radt	44	uu rowae	rmil	.i Road Be	Ltsvi	lle, Md.	20705
r			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	it caused the death n each line.	n. Do not ent	er the mode of dy	ng, such as	s cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	ORONAR		CTERY	Dise	ASE			
	Examiner			to (or as a consequ DIABETE		YELLITUS					
	p #	ner	Sequentially list conditions.	to (or as a consequ					-		
	and I-trans	Examiner	that initiated events c.	to (or as a consequ	ience of):						
8760,	the death certificate be executed y the attending physician and ached for use as the burial-transit	dlcal E		(-5.105 5.7,						
9	ifficate g phy as the	edic	V								
Вох	eath certific attending p	an/N	23b. Was decedent pregnant	outcome of pregnal		Ectopic pregnanc	Y			23d. Date of del Month	iv <i>e</i> ry Day Year
о. П	ne dea the at thed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	egnant at time of de known	eath 5□	Other (specify)			-	WOITH	Day Teal
Ω.	res that the de igned by the be detached		Part II. Other significent conditions contributing to	death but not resu	ulting in the u	nd <i>erl</i> ying cause gi	ven in Part	I. 23e. I	Did tobacco	use contribute to	the cause of death?
Records,	- 97 0	ed by							☐ Yes 2	2□No 3□Pr	obably 4 Unknown
eco	e law requ has been je 2 shouli	Completed							Vas an utopsy	24b. Were au	utopsy findings available completion of cause of
E B		Соп						1 🗆 Y	erformed? es 2 N	death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	- ×	50/0	Ot		e of Death (Check o		- 50	
oţ	Phys or this oral dir	n: To	27. Manner of Death 28a. Da	te of Injury	ER/Outpatien 28b. Time of	28c. Iniu	rv at	lursing Home 5 1 1 28d. Descr		6 ∐Other (Specury occurred	city)
ion	Attending F r death. ector: After by the funer	atio	2 Accident investigation	onth, Day Year)	Injury		rk?]Yes 2.⊑]No			
Division of	or Atterderinector	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla bu	ice of Injury - At ho ilding, etc. (Specify	me, farm, str	eet, factory, office			on (Street a Town, Stat		ural Route Number,
	pital o	O	29a. Certifier Certifying Physician: To	the heet of my know	wladna dash	occurred at the	me date a	nd place, and due to	the cause/	s) and manner as	stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the								
	To th withir To th comp	Me	29b. Signature and title of certifier				se number		}	ate signed (Monti	
)	7		Havari Temesen				6576	÷	9	1/28/0	5
			30. Name and address of person who completed a Hawani Temesgen, M.D. 6	ause of death (Item 104 Old F	23a) (Type, Branch	Print) Ave. Ter	mple M	Hills. Mar	vland	20748	
	Sta	te	31. Date filed (Month, Day, Year) 32					rial	<u>1 Taria</u>	20/40	
	Registr		SEP 3 0 2005	. Registrar's Signal	U. KA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 33374 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** onaway 11:59 2005 4a. Facility Name (If not institution, dive street and number) Dept 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** lalbot aston House Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Months Hours 1 M 2 □ F Maryland Director 214-30-7839 Jan 21, 1929 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mantal Hygiene.
ant: if item 27 is marked other than "naturel", or Items 23a or 28a-f show ant: if item 27 is marked other than "naturel", or other traumatic event, if a Marical Evantier must be rotilized at Maryland 1 Yes 2 ☐ No Dorchester Vienna Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 4821 Old R+ 50 21869 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give / `Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Worker Canning Line 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alma Louise Jackson ona way James Hermon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharptown Road, Mardela Springs, MD 21837 Conaway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 1, 2005 East New Market, MD permit, Page Department of Important: If any Injury or once. Zion Lemetery `4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home 510 Washington St, Cambridge MO st, 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arcmomit 0/1160 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. P the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No. 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 2 No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) P 1 ☐ Yes 2540 this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Atural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Zya. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Achillus M. S. Z. Collin (

122388

Herlock not 21643

sept.29,2005

Year

29d. Date signed (Month, Day, Year)

2. Date of Death Month

Physician

1. Decedent's Name (First, Middle, Last)

×	Physici /Medic		Mae Elizabeth	Cullember				Septer	nber 25,	2005 9:20 P. M	
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Tow	n, or Location of [4c. County of		
			Calvert Memorial	l Hospital		Prince	Frederi	ick	Calver	t	
	Funeral Director		5. Social Security Number 219–12–3551	6. Sex 1 M X F 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month, D	27, 1923	9. Birthplace (State or Foreign Country) Maryland	
	aryland •how	or	Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc					10d. Inside City Limits 1 ☐ Yes ※☐ No	
	28a-1	Director	Maryland Calvert 10e. Street and Number	t Pri	nce Fre	ederick 10f. Zip Cod			10g. Citizen of W	hat Country?	
	23a or		470 West Dares E	Beach Road		20678			United	,	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f show other traumatic event, its Medical Examinat must be invitibed.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	If	Vas Decedent Yes, specify (Cuban, Mexican, F	? (Specify Yes or N Puerto Rican, etc.)	Black	- American Indian, , White, etc. White	
15-0	in 72 ho n "natur lealical	Completed	15. Decedent's (Specify only highest	t grade completed)	(Give k	ent's Usual Ockind of work do	ne during most of	l working	16b. Kind of Bus		
212	with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	House	wife			Homemak	er	
힏	be filed tal Hygie d other	Bec	17. Father's Name (First, Middle, La	ast)			18. Mother's	Name (First, Middle	e, Maiden Sumame)	
Jai	should b nd Ments marked umatic e	To	James Arminger				Lelia	n Wood			
Man	and 2 sho salth and I n 27 is mu		19a. Informant's Name/Relationshi Barbara Ann Phig		,			n Rural Route Numb nady Side		, , /	
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other ODCS.		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Spe	3 □Removal from State	Place of Disposemetery, cremoury Cer	metery	place) 9,		Barstow,	City or Town, State Maryland	
Balt	permit. Departrimports eny inje		21. Signature of Funeral Service Li	icengee	1			Rausch Fi Road, Port		me, P.A. Maryland 20676	
in the second	Physician /Medical Examiner		23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ic f	er the mode of		ailer		Approximate Interval Between Onset and Death	
*		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	uence of):						
8760,	cate be execu physicien and the burial-tra	dical Exar	that initiated events resulting in death) Last	c Due to (or as a consequence of the consequ	uence of);						
.O. Box 68760	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	nysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3 □t	Ectopic pregna Other (specify			23d. Date Mont	of delivery th Day Year	
rds, P	quires that the sound on signed by uld be detacted	ed by Ph	Part II. Other significant condition Congestive	15 contributing to death but not resu	ulting in the und	derlying cause	given in Part I.	i	1	oute to the cause of death? B Probably 4 Unknown	
Vital Records,	The law requirence has been sind bage 2 should b	Completed	UMass	in Rig	he	Bre	usl	24a. Was	psy promed? de	ere autopsy findings available for to completion of cause of lath? Yes 2 \sum No	
Ita	ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only			
	Physician: r this certific ral director,	To	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2		3L DOA		ng Home 5 ☐ Res	☐ Residence 6 ☐ Other (Specify)		
Division of	or Attending Physician: The infer death. Director: After this certificate ha in by the funeral director, page		27. Mannef of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of Injury		njury at Nork? □Yes 2□No	28d. Describe	how injury occurre	d	
Divis	i or Attending F after death. I Director: After d in by the funer	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, offi	Ce	28f. Location City or To	(Street and Number wn, State)	r or Rural Route Number,	

Registrar

State

29a. Certifier

29b. Signature and title of certifier

Anwar T.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 9 2005 Blogues

32. Registres Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Munshi, MD, 110 Hospital Road, Suite 303, Prince Frederick, MD 20678

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 27, 2005 10:10 p M **Physician** Velma Crandell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 6. Sex Months 1 □ M 2X□ F Director 94 April 24,1911 <u>378–12–7956</u> Canada Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "neturef", or Items 23e or 28e-f ehow treumatic event, the Madical Examinar must be mailfied at 1 ☐ Yes 2 🙀 No Director MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 118 20736 Cross Point Drive U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: if Item 27 is marked other then "neturel", or Ite ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Marion Dille Violet Elizabeth Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis K. Oakland, daughter 118 Cross Point Dr., Owings, MD 20736 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: if any injury or once. '4 Donation 5 TOther (Specify)enfombment So. Memorial Gardens 10/03/2005 Dunkirk, MD f Funeral Service Licensée 22. Name and Address of Facility sebal Rausch Funeral Home, P.A., Owings, MD 20736 23a. Partt. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Intraabdom, na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Digitet 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3∑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funerel Director; After t Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a to Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 33123 September 28, 2005 30. Name and address of son who completed cause of de tem 23a) (Type, Print) Jonathan Lowenthal, M.D., 110 Hospital Rd. Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registres Signature State 2 8 2005 Registrar

DHMH 17 Rev 1/2001

		ľ	For State Registrar		State of N	/larylan		artment of F		and Me		iene ()	05	33377
			1. Decedent's Name (First, Middle, Last,)					2.	. Date of Death	h		3. Time of Death
П	Physici /Medic		Carol	Gwe	endolyn		Cremo	onese		S	eptembe	Day er 27,	Year 2005	4:20 a M
	Examin		4a. Facility Name (If no					4b. City, Town, o	r Location o	of Death	•	4c. Cour	nty of Death	
			9100 Bay					North I				C	alvert	
	Funeral		5. Social Security Num		х]м 2√ДF		last birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min.	. Date of Birth (Month, Day,	Year)	Cour	place (State or Foreign
	Director	}	220-38-11 Usual Residence of D	62	Λ	62	113.	ll		D	ec. 3,	1942	Kent	ucky
	/land			0b. County		10c. Cit	y, Town or Lo	ocation		-			1	0d. Inside City Limits
	Man,	to	MD	Calver	t			North Be	each					Yes 2 No
	or 28g	Director	10e. Street and Numb	er				10f. Zip Code			10	g. Citizen o	f What Cour	ntry?
	72 hours after deeth with the Maryland naturel; or Items 23a or 28a-f show Jical Exactinat the notific of all		9100 Bay	Avenue,	# 401				20714	4		U	SA	
	eep r	Funerai	11. Marital Status		 Was Deceder Armed Force 	s?	.S. 13.	Was Decedent of H	lispanic Orig	gin? (Specif i, Puerto Ric	y Yes or No- an, etc.)		ace - Americ	
36	or it	ьу Fu	1 ☐ Never Married 3 ☐ Widowed 4		1 ☐ Yes 27 If Yes, Give		i i	1 ☐ Yes 2X No	Specify:			Spec	cify: to -	±0
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212	e filed within at Hygiene. other than "	mo	Elementary/Second	ary (0-12)	College (1-4d	or 5+)	ho	memaker				own	home	
	be filed within 72 hours after deeth with the Marylan stal Hygiene. Id other than "naturel; or items 23a or 28a-1 show or other than "naturel; or items 23a or 28a-1 show avent, it a Maritsal Exacting at most be notified at	Be C	17. Father's Name (Fi	rst, Middle, Last)					18. Mothe	r's Name <i>(F</i>	First, Middle, M	faiden Sum	ame)	
<u>Ja</u>	should be and Mental a marked o umatic eve	To	Richard	Layto	n Mo	ore			Mary	<i>I</i>	Rose	Fr	ymire	
Maryland	C1 (0) == 0	0. 3	19a. Informant's Nam	e/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (Street						
	5 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m	1 3	Nicholas J		ese, Jr.			P.O. Bo	0x 143					
Baltimore,	0 0		20a. Method of Dispos 1 ☐ Burial 2 ☑	Cremation 3 P	Removal from Sta	te C	cemetery, crei	sition (Name of matory or other place		Date			n - City or To	
ţ	tmen tant: ijury		4 □ Donation 5			Met	-	tan Crema			-05	Alexa	ndria,	VA
Bal	permit. Page Department Important; if any injury o		21. Signature of Fune	om R	Gron	~		Name and Address Rausch Fu		•	P.A.,	Owing	gs, MI	20736
г			23a. Part1. Enter the shock, or heart f	disease, or compl ailure. List only or	ications that caus ne cause on each	ed the deat line.	h. Do not ent	er the mode of dyin	g, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)		Due to (or a	as a conseq	uence of):		/	/				
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_#	be executed icien and burial-transi	xar	that initiated events resulting in death) Las		Due to (or a	as a conseq	uence of):						-	
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89	g phys as the	edic												
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent p	regnant 2	3c. If yes, outcon			Testonia erosanas				23d. E	ate of delive	ery
-	death e atte	icia	in the past 12 mg		1 ☐ Live birth 4 ☐ Pregnant	at time of d		Ectopic pregnancy Other (specify)				,	Aonth	Day Year
P.0	that the de ed by the a detached	hys	9 Unknown		9□Unknown									
	res tha igned be det	by F	Part II. Other significa	ant conditions cor	ntributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I.			-1		ne cause of death?
ecords,	w requires been sign should be	ted									1 🗌 Ye	s 2 No	3 🗌 Prob	ably 4 Unknown
ecc	aw as b 2 s	pie									24a. Was an autopsy	,	prior to cor	psy findings available mpletion of cause of
Œ.	Th ate pag	Completed									perform 1 ☐ Yes 2	ied? X No	death?	2□ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred examiner?	L	Hospital:			Oth	-	of Death (C	Check only one)		
of	tending Physicien: Jeath. tor: After this certific: the funeral director,	7	1 ☐ Yes 2 X No 27. Manner of Death	,	1 🗀 Inpa		ER/Outpatier 28b. Time of		4 🗀 190		5 X Resider 1. Describe hove			y)
no	ing After une	tion	1 Natural	5 Pending investigation	28a. Date of Ir (Month, I	Day Year)	Injury	Wor	k? Yes 2⊟1		1. Describe no	w mijary coc	uned	
Division of	Attending r death. ector: After oy the fune	fica		6 Could not be	28e. Place of	Injury - At h	ome, farm, str	eet, factory, office		_	Location (Str	eet and Nur	nber or Rura	l Route Number,
Ω	or Oir	Certification	4 Homicide	determined	building,	etc. (Specif	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town,	State)		
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 (Check only 2	Certifying Phy	sician: To the be ner: On the basis and manner	of examina	owledge, death	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and th occurred	d due to the car at the time, da	use(s) and r te and place	nanner as si e, and due to	ated. the cause(s)
	o the ithin i o the omple	Mec	29b. Signature and titl	le of certifier	und manner	olulou.		29c. Licens	e number		29	d. Date sign	ned (Month,	Day, Year)
)	⊢ ≯ ⊢ ŏ			m/. 6	aalla			100	017	74		9, 9	27.0	5
7			30. Name and address	s of person who	ompleted cause of	f death (Iten	n 23a) (Type	Print)		/		11.5	110	5 D 20639
	10		MAHI	NYAZ			P.O.1	30X 37L	7 }	+UNT	11/27	ann	1 N	D 20639
	Sta	te	31. Date filed (Month,	Day, Year)	32. Regis	strans Signa	ature	Sox 370	,	- 7 /				
	Registr	ar	9	SEP 2	3 2005	Me Tour	· K	South)						

			1 - For Stata Registrar	State of Maryland	·		alth and M		•	33378
	Physici /Medic	ai	Decedent's Name (First, Middle, La Paul Richard (4a. Facility Name (If not institution, given the second se	Crissman, Sr.		City, Town, or Lo	cation of Death	2. Date of Dea Month		6:00 a M
*	Examir Funeral Director	er	Southern Mary 5. Social Security Number 6.5		ast birthday) If l	C1 i	nton Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Prince	George's inhplace (State or Foreign country) aryland
	within 72 hours after death with the Maryland ene. than 'naturel', or items 23e or 28e-f show ta Medical Eneminer man be mulified at	Director	10a. State 10b. County	oc. City,	, Town or Location		kirk	1	0g. Citizen of What C	10d. Inside City Limits 1
336	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, it is Medical Examinat mant be nutified at	by Funeral	1224 Prince St 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Teet 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 1 No If Yes, Give Y Year or Dates:				ecify Yes or No- Rican, etc.)	USA 14. Race - Arr Black, Wh	
21215-0036	ad within 72 hou giene. er than "nature", ire Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1.2		(Give kind life. DO N	Usual Occupation of work done during OT use retired)	ing most of work	ring	16b. Kind of Busines	s/Industry
Maryland	S should be filed and Mental Hygid is marked other aumatic event, iii	To Be (17. Father's Name (First, Middle, Last Paul Fugene Ci 19a. Informant's Name/Relationship (rissman	19b. Mailing Ad		Hilda	Rae Me	Maiden Sumame) tzinger , City or Town, State,	Zip Code)
Baltimore, M	Health tem 27 other tr		Cheryle Crissma 20a. Method of Disposition 1	☐Removal from State 20b. Pla	1224 I ace of Disposition metery, crematory. Memor	(Name of y or other place)	1	Date	irk, MD 20c. Location · City o Dunkirk,	r Town, State
Balti	permit. Pages Department of Important: If I any Injury or ones.		21. Signature of Funeral Service Dice	nsee	22. Nar	ne and Address o	Racility Racility Racility	ymond- irk, M	Wood F.H D 20754	
}	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a	typoi	Tensio				Interval Between Onset and Death Lin Know
3760,	te be executed ysician and te burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)	atie .	ENCE	o hal	pal	<u> </u>	
.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □Ecto	pic pregnancy er (specify)			23d. Date of do Month	elivery Day Year
Δ.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions Alma Faul		lting in the underly	ring cause given i	n Part I.	1 🗆 Ye	es 2□No 3□F	to the cause of death? Probably 4 Donknown
Vital Records,	sician: The law certificate has t irector, page 2 s	Be Completed	25. Was case referred to medical examiner?	ine.			6. Place of Deat	24a. Was a autops perform 1 Yes 2	y prior to death? 2 1 Ye	autopsy findings available completion of cause of
Division of \	tending Physician: The leath. for: After this certificate hathe funeral director, page	ation: To	1 Yes 2 To 27 Manner of Death 1 Datural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?			ence 6 Other (Sp ow injury occurred	ecify)
DIVİ	To the Hospital or Attentwithin 24 hours after deatl To the Funaral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)) vledige, death occi	rred at the time.	data and pless	City or Town	tuise(s) and manner a	is stated
	To the Ho within 24 I To the Fu completel	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	miner: On the basis of examinati and manner stated.	on and/or investig	29c. License ni			ate and place, and du	
	ő		30. Name and address of person who	Ave Sut 3-4	1 -3,14	en Spe		1 azd	ani, M	lip.
A STATE OF THE PARTY OF THE PAR	Sta Registi		31. Date filed (Month, Day, Year)	32. Registry's Signature 6 2005	J. J. A.	barker				

			1 - For State Registrar	State	of Marylan		artment of F rtificate of				gle pe Reg. No.	UO	33319
	Dhysia		1. Decedent's Name (First, Middle	, Last)					2	2. Date of De Month	ath Day	Year	3. Time of Death
	Physic /Medi		Jeanne Patricia	DARR					0	ctober		005	4:45 p.M
	Exami		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location	of Death			unty of Death	
н			16505 Virginia	Avenue,			William					ashing	ton
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21 F	7. Age (In yrs.		If Under 1 Year Months Days	If Unde Hours	Min.	B. Date of Bin (Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
Н	Director		341-18-5044	1 M 2 A F	82	Yrs.			F	eb. 12	,1923	I11:	inois
	P R		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or L	ocation						10d. Inside City Limits
	aryla shor	2		ngton	700.01		amsport						1 ☐ Yes 2 🖾 No
	88-1-1 N	ecto		ing con		WITII					40.00		
	vith t	Dir	10e. Street and Number	•	a	1/1	10f. Zip Code					of What Cou	ntry?
	ath v	rai	16505 Virginia				21795			76 24	USA	D	and the disc
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: it Item 27 is marked other then "naturel', or Iteme 23a or 28a-f show any injury or other treumatic event, Ite Medical Exactif at rural be nutified at once.	by Funeral Directo	Marital Status Never Married 2 Married 3 Widowed 4 Divorced	Armed F	2 ∑ No ive	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic O an, Mexica Specifi		ify Yes or No ican, etc.)		Race - Americ Black, White, ecity: wh:	etc.
21215-0036	hou ture	edt	15. Decedent			16a, Dece	dent's Usual Occup	pation			16b Kind	of Business/In	dustry
15	in 72	Completed	(Specify only highes	t grade completed)		(Give	kind of work done DO NOT use retired	during mo	st of working	7			,
12	there is	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker				her	own he	ome
D	fited Hyg offheir ent,	Ü	17. Father's Name (First, Middle,	Last)		1		18. Moth	ner's Name (First, Middle,	Maiden Sui	mame)	
an	d be ental ked o	To Be	Bernard Anders	on				Ha	zel Be	atty			
Maryland	12 should be filed within ' h and Mental Hygiene. 7 Is marked other then " reumatic event, it e Med	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street	and Numi	ber or Rural i	Route Numbe	er, City or To	wn, State, Zig	Code)
S	lith ar		Nancy Rothrock	- daught	er	522	B Hollow	Tree	Lane.	Keedv	svill	e. Md.	21756
စ်	Hea Hea tam		20a. Method of Disposition				osition (Name of matory or other place		Dat			ion - City or To	
Baltimore,	nt of nt of t: It it		1 Burial 2 Cremation		State				10/7/0	05	Hann		No writend
Ē	it. P		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		Ilag	•	wn Cremat 2. Name and Addre	,					, Maryland
Ba	Depar Impo any ir		1 Bolutis	Canhe		4	15 E. Wil	son l	Blvd.,	Hager	stown		21740
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on o	caused the deatl	h. Do not en	ter the mode of dyin	ng, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition	Hype	rtensiv	e Card	iovascula	ar di	sease				Onset and Death
	/Medical		resulting in death)		(or as a conseq								
	Examiner		Conventielly liet annulities	h .									
		ne.	if any, leading to immediate	Due to	(or as a conseq	uence of):							
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate class or injury that initiated events	c.									
ó	an ar rial-tu		resulting in death) Last	Due to	(or as a conseq	uence of):							
68760,	tificate be executed ig physician and as the burial-transit	edicai		d.									
99	tifica ig ph as th	led			+.								
Вох	eath cert attendin for use	2	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Testania programa.				23d.	Date of delive	эгу
ю. В	The law requires that the death certificate be executed tie has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of de		Ectopic pregnancy Other (specify)					Month	Day Year
<u>ر</u>	s thal		Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the u	nderlying cause giv	en in Part	l.	23e. Did to	bacco use d	contribute to th	ne cause of death?
ds	quires n sign	d b	Diabetes Mel	litus Typ	e II					1 □ Y	es 2 🖾 N	o 3□Prob	ably 4 Dunknown
00	w require been sign should b	Completed by	Hypothyroid							24a. Was	an 24	4b. Were auto	psy findings available
Re	he la e has ige 2	m.								autop	med?	prior to cor death?	mpletion of cause of
a			OF Man ages referred to modical							1 Yes		1 🗆 Yes	2□ No
Ξ	Physicien: The law this certificate has bral ral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:		FB/0-1	ot 300 DOA Oth	00		Check only or			
of Vital Records,	Phy ral d	H 3	1 🔀 Yes 2 □ No 27. Manner of Death		Inpatient 2 of Injury	28b. Time o	1 3 3 50 7	4 🗆 14		d. Describe h		Other (Specify	/)
u O	ding f h. After funer	tion	1 ☑ Natural 5 ☐ Pending		of Injury th, Day Year)	Injury	Worl	k?¨ Yes 2.⊑			· · · · · · · · · · · · · · · · · · ·	001100	
2	deatl deatl ctor: / the	ica	3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At ho	me farm str	eet, factory, office			f Location (S	treet and No	ımher or Rura	I Route Number,
Division	or A after Direct in by	Certification:	4 ☐ Homicide determi	ned build	ing, etc. (Specify	()	eet, factory, office		201	City or Tow		moor or riting	7710010110011
	spitel ours ours ours ours filled		29a. Certifier 1 ☐ Certifying	Physician: To the	a best of my kno	wiedne deat	occurred at the tire	ne date a	nd place, and	d due to the o	ause(s) and	manner as st	ated
	To the Hospitel or Attending Physicien: whin 24 hours after dealy within 24 hours after dealy of the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medical E	xaminer: On the b	asis of examination and stated.	tion and/or in	vestigation, in my of	pinion, de	ath occurred	at the time, o	date and place	ce, and due to	the cause(s)
	Withir Youth	ž	29b. Signature and tiple of certifier	_			29c. License	e number		2		gned (Month,	* * * * * * * * * * * * * * * * * * * *
1	12		Shire	121 5	1. Heo 7	VI 14	D0106	2			Octob	er 6,	2005
-	' 1		30. Name and address of person v	who completed caus	se of death (Item	23a) (Type,	Print)						
	U		Edward W. Ditto					r. Ro	l., Ha	gersto	wn, Ma	aryland	1 21742
	Sta	te	31. Date filed (Month, Day, Year)	1	4 5		-					-	
	Registr		OCT 0 7	2005	gistrar's Signal	0. P	rede						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiep 0.533380 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LM GUSPM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner g. MONTHOMEN AS CHEN TALLOMA 707 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday. Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 XF Director New York 462-10-7744 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or itema 23a or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Directo Silver Spring Marvland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 USA 8700 Reading Road r death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if item 27 ie marked other then ' ury or other traumatic event, tha Ma Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace V. Mason Richard W. Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 7030 Hunter Lane Hyattsville, MD 20782 Rachel S. Pittarelli/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 3, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: if eny injury or 2005 W. Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service Licensele Going Home Cremation Service P.O. Box 784 ouce 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** ٦ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? cate has been signed by the atte page 2 should be detached for Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 Yes To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 200 No 1 Tes Inpatient Certification; To 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the i 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -00S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) 32. Raistrar's Signature 31. Date filed (Month State 03 2005 Registrar

				For State of Mary 1 - State Registrar		artment of Health and <i>rtificate of Death</i>		1erg 005	33381
		Physici	an	1. Decedent's Name (First, Middle, Last) TAMES GERAND DU	22		2. Date of Deat Month	Dav Year	3. Time of Death
		/Media	cal	4a. Facility Name (If not institution, give street and number)	70 70	4b. City, Town, or Location of Dec		4c. County of Deatl	
		Examir	ner	HALFORD MEMOMAL HOS	PITAL	HAVRE DE		HARF	
	Ī	Funeral Director	П	140-42-3552 ^{1⊠ M 2□ F} 57	yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hours Min	s. 8. Date of Birth	Year) 9. Birth Co.	nplace (State or Foreign untry) New York
		and and		Usual Residence of Decedent 10a, State 10b, County 10	c. City, Town or Lo	cation			10d. Inside City Limits
		Maryl 1 sho	ţō	Maryland Cecil		Port Deposit			1 ☐ Yes 2X No
		th the	Director	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Co	untry?
		ath wi	rai	212 Craigtown Road, Apt. No.		21904			S.A.
	36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Items 23a or 28a-f show raumatic event, If a Medical Experient: and be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 12. Yes 2 No If Yes, Give Year or Dates: 1.9		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue □ Yes 2⊠ No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify:	
	9	2 hou		15. Decedent's Education		lent's Usual Occupation kind of work done during most of w		16b. Kind of Business/I	
	21215-0036	e. en "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)		Telso Sour	ce Corp.
	121	led wi		Twelve Years 17. Father's Name (First, Middle, Last)	Lea	d Field Technici		New Jersey	
	Maryland	d be fi	Be c	James Gerard Dunn		18. Mother's N	ame (First, Middle, M Mae Bo	,	
	Ž	d 2 should th and Mer 7 Is marke traumatic	은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or I			ip Code)
0	2	and 2 ealth a n 27 is	Ţ	Bridget Wiese (Daughter)	6 Fil	lipponi Court, E	ordentown	, New Jerse	ey 08505
1 11	, Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trae		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 1 4 □ Donation 5 □ Other (Specify)	Ob. Place of Dispo cemetery, cren Asbury (natory or other place)		ort Deposi	own, State t, Maryland
1	Balti	permit. Departri Importe any inju		21. Signature of Funeral Service Licensee	5. Pe	Name and Address of Facility e A. Patterson & erryville, Maryla	Son Fune	ral Home,	P.A.
				23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
		Pnysician		Immediate Cause (Final disease or condition resulting in death)	SCVD	t			Onset and Death
		/Medical Examiner		Due to (or as a co	nsequence of):				
2			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of the hat initiated events c.	nsequence of):				
9	ay.	ocuted nd transit	Examiner	that initiated events resulting in death) Last Due to (or as a co					
130/0	8760,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last Due to (or as a co	nsequence of):		<u>-</u>		
0	9 ×	n certific anding pl use as I	/Mec	IF FEMALE: 23c. If yes, outcome of pr	eon ancy				
	P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Ves} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \) Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)		23d. Date of deliv	rery Day Year
	G,	ss that gned by	by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the ur	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	ord	w requires that been signed I should be det					1 Ye	s 2□No 3□Pro	bably 4 Unknown
8	Il Records,	ysicien: The law is certificate has b director, page 2 st	Completed				24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
2	Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	eath (Check only one		
Ames	o	Phys or this oral di	7: To	27. Manner of Death 28a, Date of Injury	2 ER/Outpatient 28b. Time of	28c. Injury at	Home 5 Resider 28d. Describe how	nce 6 Other (Speci w injury occurred	(v)
7	ion	tending Ph Jeath. tor: After th the funeral	atio	1 S Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	ar) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DUNN,	Division	tel or Attendest s after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre	et, factory, office	28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
3		To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death mination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
		To T Com	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month,	-
		WILLIVA		20 Named address of the	OME (Itam 23a) (Tura I	321809		SEPT 30,	2005
		14/11		30. Name and address of person who completed cause of death $G + P - A + B + U + M - D - 233$	6 40 n	· · · · · · · · · · · · · · · · · · ·	NIUM V	40 Z109	3
		Sta Registr		31. Date filed (Month 1997 Yep) 3 2005 32. Figistrar's S	Signature	park			

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 12:45 PM Decker Doris October 10,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Lions Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jun 9, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 91 Director 218-80-9312 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other treumetic event, the Madical Examinat must be multiled at once. 10c, City, Town or Location 10a. State 10d. Inside City Limits MD Allegany Cumberland YUYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 814 Manns Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Zorick Frank Zorick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Argyle Drive Sanford NC 27332 19a. Informant's Name/Relationship (Type, Print) 503 Argyle Drive Carol Saliga daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/2005 Cumberland MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. NamScarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Multiple Physician Inknow disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier restriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 #D0060478 October 11, 2005 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 625 Kent Ave. Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

MD

32. Registrar's Signature

Glows S.

DECKER

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Severna Park

8. Date of Birth (Month, Day, Year) Aug. 9, 19 **Funeral** Days Hours 1 M 2 F Yrs Director 76 220-24-7788 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f ebov traumatic event, the Mudical Exam par must be notified at Anne Arundel Severna Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or: any injury or other traumatic event, Ite Mudical Exam. 21146 621 Center Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ lf Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frederick Brookhart Edith Frampton 2 19a. Informant's Name/Relationship (Type, Print) Karl F. Decker/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 28, 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Fuheral Service Licensee 23a. P 41. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or h art failure. List not one cause on each line. mediate Caure (Final isease or condition esulting in death) BILIARY PRIMARY CIRRHOSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of): 68760, attending physicien Physician/Medicai Box IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certified 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Park Road, Severna Park, MD 21146 20c. Location - City or Town, State Crownsville, MD 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 🗷 No 3 Probably 4 Unknown 1 Tes 24a. Was an Were autopsy findings available prior to completion of cause of death?
 1 □ Yes □ 2 □ No autopsy performe 2 ≥ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) D23060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 171 Defense Hwy Annapous MO 2140

33383

3. Time of Death

5:00 a

Birthplace (State or Foreign Country)

MD

1 ☐ Yes 2 No

10d. Inside City Limits

Anne Arundel

Reg. No.

25, 2005

4c. County of Death

USA

Race - American Indian, Black, White, etc.

Westinghouse

White

2. Date of Death

Month

Sept

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

For State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

621 Center Drive

MARGARET

4a. Facility Name (If not institution, give street and number)

SEP 2 8 2005

ANTHONY J. CALABRESE 32. Digistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 15 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** September 27, 2005 9:00 A John Alan Douglass, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert County Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Yrs Director 57 May 5, 1948 Pennsylvania 169-40-4972 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Itam 27 is marked other than "natural", or Itame 23s or 28s-f show other traumatic avent, the Modical Exporter roset be notified at 1 XYes 2 □ No Director MD Calvert County Chesapeake Beach 10g. Citizen of What Country? 10e. Street and Number 7504 E Street 20732 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Itam any injury or other traumatic avant, the Mudical Exercited page. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sprinkler Fitter Local Union #669 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Myron Wayne Douglass Julia Etta French ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7504 E Street, Chesapeake Beach, Maryland 20732 Joanna M. Douglass (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 28. 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Lee Crematory Clinton, Maryland 21. Signature of E 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner TOU DISTASS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a cons Box 68760. Physician/Medical as IF FEMALE nse 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months 1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ٩ 1 Yes 2 No 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signatur 29d. Date signed (Month, Day, Year) 40037228mD

State Registrar 225 Town Square Drive, Lusby, Maryland 20657

mp eted cause of death (Item 23a) (Type, Print)

Stephen P. Cafferty, DO 225 To 31. Date filed (Month, Day, Year) 32. Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of Arrival Projects of Maryland / Department of Health and Mental Hygiene of Arrival

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	e <i>rtificate of</i>	Health and Me Death	niai mygie Reg		33385
			Decedent's Name (First, Middle, La	ist)			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Lonnie Ruhl Dunk	ar				eptember	23, 200	
	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Dea	
		Н	1950 Rosemary Lar 5. Social Security Number 6.5		e (In yrs. last birthda	Port Rep			Calvert (
	Funeral Director		136–36–5552 Usual Residence of Decedent	1XM 2□F 58		Months Days	Hours Min.	Date of Birth (Month, Day, Young)	1946 Wes	thplace (State or Foreign ountry) st Virginia
	yland yow		10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
	Mar-fat-	ctor	MD Calvert	County	Port Re	public				1 ☐ Yes 2 🛣 No
	or 28	Jire	10e. Street and Number			10f. Zip Code			. Citizen of What C	ountry?
	ath w	rail	1950 Rosemary Lar			20676			U.S.A.	t-dia-
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Marice. Existing in institution of motified at anote.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Speci an, Mexican, Puerto Ric Specify:	ry fes or No- can, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	n 72 ho "natur	ietec	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of working id)	16	b. Kind of Business	/Industry
212	i withi	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	omotive P			ederal Go	vernment
	be filed tal Hygie d other evant, the	BeC	17. Father's Name (First, Middle, Las.	"			18. Mother's Name (/			
/lar	should be and Menta a marked umatic ev	To E	Ruhl Lee Dunbar				Sybil Ile	ene Mint	on	
Maryland	2 sho and I la ma		19a. Informant's Name/Relationship	(Type, Print)		_	t and Number or Rural F			
	l and lealth im 27 iher tr		Sharon L. Dunbar 20a. Method of Disposition	(Wife)	1950	Rosemary	Lane, Port	Republ	ic, Maryl	and 20676
Baltimore,	Pages ment of Hant: If ite		1 ☐ Burial 2 X Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci	fy)	Lee Crem	atory or other pia	2005	25, C	linton, M	aryland
Ball	Depart Import any in		21. Signature of Fundal Region Lies	nsee	8	22. Name and Addre	^{ess of Facility} Lee I ern Marylar	uneral l	Home Calv	vert, P.A.
	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mode of dyi	ng, such as cardiac or r	espiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				RCINOMI			Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):					
	Laminer	<u>.</u>	Sequentially list conditions,	b. ————————————————————————————————————	a consequence of):					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (51 40						
,	execun nand ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	tificate be executed ig physician and as the burial-transit	edicai		d						
	ntifica ng ph s as th	_	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
	that the by deta	y Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
rds	quires in sign	q pa	Renac (ELL	- CARCIA	Joma			1 🗌 Yes	2 10 № 3 □ P	robably 4 Unknown
Records,	aw recision speed states	piet						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Re	The law	no						performed	d? death?	2 No
Vital	ysician: The lis certificate hadirector, page	BeC	25. Was case referred to medical examiner?				26. Place of Death (6	Check only one)		
of V	Physician: this certific ral director,	은	1 Yes 2 1 H6		ent 2 ER/Outpati	BIL 3 DOA			e 6 □Other (Spe	ocify)
on C	tel ne	ion:	27. Manner of Death 1 Deatural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wo	ry at 286 irk?]Yes 2 □ No	d. Describe how	injury occurred	
Division	Attanding r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not l	De Dines of In	jury - At home, farm, :			. Location (Stree	at and Number or R	ural Route Number.
Ď	after Dirac	Certification:	4 Homicide determined	building, el	c. (Specify)	moon, nationy, office		City or Town, S		,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis o and manner st	f examination and/or	ath occurred at the ti investigation, in my	ime, date and place, and opinion, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier		0 0	29c. Licen		29d.	Date signed (Mont	
			XIIO KIC "	X Ja	(has	D3	9550		9-23.	-05
	10		30. Name and address of person who	completed eause of a	death (Item 23a) (Type	Print) PSO Forl	bes Blad (Canham	, md	20706
	Sta Registi		30. Name and address of person who George C- H 31. Date filed (Month, Day, Year) SEP 2	32. Registr	Signature	Scente	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0533386 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dudiak 1:45PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14505 N. Bel Air Dr. SW Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Sep 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral ½**□M 2□F 1921 288-18-8072 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be multified at MD Allegany Cumberland 1 LYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14505 N. Bel Air Drive SW 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↓ Yes 2 No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white Baltimore, Maryland 21215-0036 Š 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me gange. Elementary/Secondary (0-12) College (1-4or 5+) Army Corps of Eng. Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Dolly Terrace MD 21502 LaVale Jon Dudiak son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/8/2005 Cumberland MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Home, P.A. 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumperland, MD 21502 23a. Prov. Erver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thick, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ARTERIOSCLERONC HEART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The faw requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? 1 ☐ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home <u>1</u>0 2 ER/Outpatient 3 DOA Tesidence 6 □Other (Specify) 28d. De cribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-5-2005 D09157 address of person who completed cause of death (Item 23a) (Type, Print) 124 W. 3rd Street Cumberland MD 21502 Paul Snow M.D. Registrar's Signature State OCT 1 4 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 1 1 5 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** DHAYER GERALD BOUGLAS October 21:230 10 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-20-51 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1**☑**M 2□F Weirton: WV 54 Director 233-84-4413 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Berkeley Springs 1 ☐ Yes 2 ☐ No Morgan WV Director 10g. Citizen of What Country? 10e. Street and Number 3077 Valley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or lies any injury or other traumatic event, the Madical Examines once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eddie's Tire Service Elementary/Secondary (0-12) College (1-4or 5+) Vice President & Owner yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marlene Ankrom Dhayer Oliver Lee Dhayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3077 Valley Rd., Berkeley Springs, WV 25411 Deborah J. Dhayer - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 10-11-05 Smithsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licenses 22. Name and Address of Facility Hunter-Anderson Funeral Home 36 S. Green St., Berkeley Springs, WV 25411 200 Mil 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAZ METTORRAGE Physician 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYDERPENSION UNKNOWN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐ Pregnant at time of death ed by the a detached f 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 Ë 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062448 OCTOBER 10 2005 ava 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE. NEGRAT NAVAL STRIST 600 NORTH WOLF 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 05 33388 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** SEPTEMBER 12:38A **EUBANKS** 28, 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 □ M 2017 F Yrs. unk Director JUNE 19, 1945 VIRGINIA 60 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Example at must be notified at XX Yes 2 No CAPITOL HEIGHTS PRINCE GEORGES MARYLAND Directo 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 6832 WALKER MILL ROAD 20745 Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes XXNo If Yes, Give Year or Dates: XX Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within the and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) UNEMPLOYED 9TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELLA JONES JOHN EUBANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun QDC6. MONROE, VA ELLA EUBANKS / MOTHER 3137 S. AMHERST HWY. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Y Surial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State BOLLING HILL CEMETERY 10/04/2005 4 ☐ Pogation 5 ☐ Other (Specify) AMHERST CO., VA 21. Signature of Funeral Service Loansee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD/ COMMUNITY F.H. 23a. Part | Fitter the disease, or complications that caused the death. Shock of heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death)

a. SEPSIS 4308 SHITLAND RD. SHITTLAND, MD / LYNCHBURG, VA Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner DISEASE CILL KLE C Sequentially list conditions, if any, leading to immediate cause. Liner Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner FAILURE-VENT. DEPENDANCE death certificate be executed physicien and the burial-transit RESPIRATORY Due to (or as a consequence of): Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month ō in the past 12 months? 1 ☐ Yes XXNo 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No certificate 1 ☐ Yes 1 ☐ Yes XX No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes XX No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After t Certification: or Attending 5 Pending investigation XX Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident after death Diractor: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05 person who completed cause of death (Item 23a) (Type, Print) 30. Name CHEVERLY, Md. 20785 SANJI AKHANPAL 3001 HOSPITAL DR.

State Registrar

Maryland 21215-0036

Baltimore,

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Records,

Division of Vital

OCT 0 3 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Daillinde, maryland 21213-	permit. Pages 1 and 2 should be filed within 72 h	Important: if itsm 27 te marked other than "natu	90
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I OI VII A DECOLUS, P.O. DOX 00/00,	ng Physician: The law requires that the death certificate be executed	ter this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial-transit	

		For State Registrar		State of Ma	aryland	1 / Depa <i>Cei</i>	artmer <i>rtificat</i>	e of C	ealth an Death	d Mei	ntal Hy	giene Reg. No		15	33389
Physici	_	1. Decedent's Name	JACK	,	EN 5	TAD	Т				Date of De Month	Day		Year 005	3. Time of Death
/Medic Examin	_			e street and number)			4b. City,	Town, or	Location of D		, , ,	- T-		of Death	
	3	HOWARD	COUNT	/ GENER	AL Ho	SPICAL	(3	LUM	BIA				How	ums)
Funeral Director		5. Social Security No. 090-10-9		6ex 7. Age	e (In yrs. Ia 89	ist birthday) Yrs.	If Under Months		If Under 24 Hours	lin.	Date of Bir (Month, Di	ay, Year)	15	9. Birth Coul Bron	place (State or Foreign htry) NY
pug *		Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town or Lo	cation								Od. Inside City Limits
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1 the	Director	10e. Street and Nun	mber				10f. Zip	Code				10g. Cit	izen of V	Vhat Cou	ntry?
th with	a D	5400 Van	ntage Poi	nt Road				210	44			Unit	ed S	State	S
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Important: If Itan 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 37 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:		i. 13. \	Was Dece f Yes, spe 1 Yes		spanic Origin? n, Mexican, Po Specify:	(Specification (Specification)	y Yes or No an, etc.))-	Blac	e - Americk, White,	
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permit. Departr Imports any inji		21. Signature of Fu	neral Service Lice	1500											Home, Inc MD 20904
		23a. Part1. Enter the	ne disease, or com	plications that caused one cause on each lin	the death.	Do not ent	er the mod	de of dying	, such as care	diac or re	spiratory a	rrest,			Approximate Interval Between
Physician		Immediate Cause (disease or condition	Final			20014									Onset and Death
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ne death cer the attendir hed for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal c	death 3□	Ectopic p Other (su						23d. Dat Moi	e of delive	ery Day Year
that the sed by detac		Part II. Dther signifi	icant conditions	contributing to death be	ut not result	ting in the u	nderlying o	ause give	n in Part I.		23e. Did	obacco u	ise conti	ribute to t	ne cause of death?
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Attending Physician: r death. ector: After this certific. by the funeral director.	ation	27. Manner of Death 1 Natural 2 Accident	5 Pending investigatio		Year)	28b. Time of Injury	м	28c. Injury Work 1 🗆 Y	at ? ′es 2 □ No	280	l. Describe	now inj <i>ut</i>	y occurr	ed	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined				eet, factor	y, office		28f.	Location (City or To			er or Rura	l Route Number,
e Hospit 1 24 hour 1 Funera	edical	29a. Certifier (Check only one)	12☐ Certifying Pt 2☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination	vledge, death on and/or in	n occurred vestigation	at the time , in my op	e, date and pl inion, death o	ace, and	due to the at the time,	cause(s) date and	and ma i place, a	nner as s and due to	ated. the cause(s)
withir To th comp	Me	29b. Signature and	/ .		,			c. License				29d. Dat	te signed	(Month,	Day, Year)
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		30. Name and addre	ess of person who	completed cause of d	eath (Item :	23a) (Type,	Print)	~ 5	MAGT	3A	TIMOR	E n	9 7	121 =	-
Sta Registr		31. Date filed (Mont	th, Day, Year)	completed cause of d ~ D A ~ M D 32 Registra	ar's Signatu	JE A	de								

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** HENRY ENOCH FREEDMAN 2005 October 4:06 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 15 M 2 □ F 89 24, Director 1916 Manhattan, NY 050-18-8047 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event. the Madical Examinar must be notified at 1 Yes 2 No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 6121 Montrose Road #512 20852 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Deportment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "rent plury or other traumatic event. I'm Mad ong other. College (1-4or 5+) 5 + Efementary/Secondary (0-12) Attorney Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jeanette Unknown Harris Freedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Freedman, Son 10405 Stablehand Drive, Cinncinati, OH 45242 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Removal from State 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns 10-03-2005 Falls Church, VA 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens No 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) difficile days Physician Clostridium /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed gned by the attending physicien and be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ oneumonia 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 0 24a. Was an this certificate has 1□ Yes 2□No Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ٥ 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation al or Attence after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide the Hospital chin 24 hours af the Funeral D pelli 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) licre J. Mistry October 2, 2005 D59738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year)

OCT 0 3 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 33391 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 28 2005 **Physician** Katherine S. Fitzgerald 7:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 23,1965 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country)
 MI 6. Sex **Funeral** Months 1 □ M 2 N F 40 Director 212-90-8874 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b County 10a State 10d. Inside City Limits 28e-f ehow traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 with 20874 13719 Lark Song Drive United States Items 23a death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or ite 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William J. Fitzgerald Florence E. Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health as Important: If Item 27 Is any injury or other trau-10505 MacArther Blvd, Potomac, MD 20854 Florence E. Fitzgerald/Mother 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State September 29, 2005 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee RAC TUVER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute myocardian interction **Physician** inates disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disons b. Atheroscuratic
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending shockings and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 □ No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ves 2□ No 2₽ ER/Outpatient 3□ DOA 1 Inpatient After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1. Natural 1 ☐ Yes 2 ☐ No investigation Director: d in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier September 28 2005 D0058015 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 Jonathan Wenk, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 03 Registrar

State of Maryland / Department of Health and Mental Hygiene 33392 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2:03 P M Benjamin L. Fisher SEPT. 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) OV. 11, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Hours Months Days **™** M 2□F Yrs. **1**916 VIRGINIA 88 Director 229-18-1477 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural", or items 23e or 28e-f show any injury other traumatic event, the Model Examination and be notified at once. 10a. State 10b. County 1 XYes 2 □ No Director LAUREL PRINCE GEORGES 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 U.S.A. 609 FAIRLAWN AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black. White, etc. orces. 2 No 1941-Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1945 BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMITTING CLERK V.A. HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BENJAMIN F. FISHER SARAH TOWNSEND 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LEVIA JAMES/DAUGHTER 609 FAIRLAWN AVE., LAUREL, MD. 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) QUANTICO NAT'L. CEM. 10-3-2005 TRIANGLE, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A come M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a ATHROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 YRS. Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner executed burial-transit Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1X Yes 2 🗆 No 1x Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 D35112 SEPT. 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL B. BAKER, M.D. 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 3 2005 Registrar

		•	For State Registrar	State of Marylan	d / Depa	artment of H	Health and Death		gien e (105	33393
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) ### Apple 4 4a. Facility Name (If not institution, give s	ERRY J	R	4b. City, Town, o	or Location of De	2. Date of De Month	Day	Jear JOOS unity of Death	3. Time of Death 8:30 PM
***	Funeral Director	9	5. Social Security Number 578-20-9871 Usual Residence of Decedent	7. Age (In yrs. 82	AE last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	ıy, Year)	Cour	place (State or Foreign nitry)
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Baltimore,	permit. Pages 1 Department of H Important: If Its eny Injury or oth		20a. Method of Disposition 1 1 2 Bugial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Section Licensis	Removal from State Ga	te of	esition (Name of matory or other plath	10 /	7/05	Silve		ng, Md.
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	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and pla		o the cause(s)
	2323 1.11A		29b. Signature and title of certifier,	ell, MD	n 23a) (Tun-	Print))262	78	10	- 3-	05
	171" si	ate	30. Name and address of person who co	ompleted cause of death (Itel ON STATE 32. egistrar's Sign	L HOSP	LE PUR	30x 173	78 3 Sall	sb)	MND	21802
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	/Medic Examin		4a. Facility Name (If not institution, give street and num 1715 Denton Court	nber)			Town, or	Location o			4c.	County of Deat	h	
Ī	Funeral Director		5. Social Security Number 6. Sex 176-14 32 74 1 1 1 1 M 2 F	7. Age <i>(In yr</i> s. <i>l</i> a. 86	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min	Date of Birt (Month, Da eb 15	h	9. Birt	hplace (State or Foruntry) nsylvania	
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinate with the collined at Once.	by	38 Weather Oak Hill 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Dece Armed For 1 ☒ Yes If Yes Give Year or Day	2 No 9 10/0		Was Deced	lent of His	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		USA 14. Race - Ame Black, White Specify: V		
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Mary	d 2 shouth and M. 7 is mai	-	19a. Informant's Name/Relationship (Type, Print) Kirsten Fahr (Wife)			•					-	NY 125		
altimore, I	Pages 1 and lent of Healt of Healt of Healt or: If Itam 2 ry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State Cer	ce of Disponentery, crem	sition (Nan	ne of ther place	9)	Dar -27-2	te	20c. Lo	cation - City or	Town, State	
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			30. Name and address of person who completed cause	e) of death (Item	23a) (Турө,	Print) 445	(D	EFE	WSE 1	4,640	VAry	ANNAS	2005 POLIJ M D 2	144
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State of Maryland / Department of Health and Mental Hygien 0.0533395 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30, 2005 445 F **Physician** Dorothy Evelyn Guyton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 17837 Sherman Avenue Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 2,1928 9. Birthplace (State or Foreign Country) Alabama 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 77 223-30-3168 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State itam 27 la marked other than "neturel", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at Hagerstown 1 ☐ Yes 2XXNo Maryland Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 17837 Sherman Avenue death 1 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: If itam 27 Ia marked other than "neturel", or Item eny injury or other traumatic event, the Medical Expressions. Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-12 College (1-4or 5+) hotel manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Presley Hooker Eugene ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17837 Sherman Avenue, Hagerstown, Maryland 21740 Richard L. Guyton - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 2005 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory Hagerstown, Maryland ' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 may 23a. Part 1. Enter the disease, or complications that Aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Light line. Approximate Interval Between onset and Death Immediate Cause (Final Priysician month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗌 Yes 3□ DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check one To the within 2 To the 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 362 11 nd address of person who completed cause of death (Item 23a) (Type, Print) 455 111 IIIID 31. Date filed (Month, Day, Year) 32: Segistrar's Signature State OCT 0 3 2005 Registrar DHMH 17 Rev 1/200

ORIGINAL

			For State Registrar	State of Mary	land / Depa	irtment of H <i>tificate of l</i>	lealth and M Death		iene 0 0	15 33396
			Registrar 1. Decedent's Name (First, Middle, Last)		001	incate or i	Journ	2. Date of Deat	th	3. Time of Death
	Physicia	an	Sophonia Clark G	aston				Septemb	er 29,	2005 7:45 A ^M
The second	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	-	4c. County	of Death
			Suburban Hospital			Bethesd		1		gomery
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (li	73 Yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 7,	1932	9. Birthplace (State or Foreign Country) Maryland
	ס		Usual Residence of Decedent							And Inside Challing
	arylan ehow	_	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	he Ma	Director	Maryland Montgomer	У	Silver Sp	10f. Zip Code		1	0g. Citizen of W	Vhat Country?
	with With	2	531 Randolph Road	#321		20901			United	
	death	Funerai		2. Was Decedent Eve	r in U.S. 13.		ispanic Origin? (Sp an, Mexican, Puerto		14. Race	e - American Indian, k, White, etc.
98	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. dother then "netural; or items 23a or 28e-f ehow event, the Medical Examinar must be notified at	by Fur	1 Never Married 2 Married	1 ☐ Yes 2 █ X No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	110411, 510.7	Specify	D11-
Ş	hours tural',	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Deced	ient's Usual Occup	ation		16b. Kind of Bu	siness/Industry
5.	within 72 ene. then "ne ne Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of work d)	ang		
27	e filed within al Hygiene. I other then ' vent, the Ma	Com		1	C1e	erk			Verizon	
Ē	be fife that Hy event	Be	17. Father's Name (First, Middle, Last) James Clark, Sr.				18. Mother's Nam Elenora		Maiden Sumam	Θ)
<u>≅</u>	should be and Menta marked umatic ev	2	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or Rur		r, City or Town,	State, Zip Code)
	nd 2 solith and 2 solith and 2 solith and 27 io		Joyce Gaston	(daughter			St. N.W.			
ore,	es 1 and 2 should b of Heelth and Ment 1 trem 27 ie marked r other traumatice		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo cemetery, crer	sition (Name of natory or other place		Date	20c. Location -	City or Town, State
ii	Pag ment tant: it		4 □Donation 5 □ Other (Specify)		Washingto					d, Maryland
Baltimore,	permit. Pages 1 Department of H Important: if its any injury or ot		21. Signature of Funeral Service Licens	Clypha			ss of Facility Mc(ia Ave. 1			
			23a, Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
d.	Physician		Immediate Cause (Final disease or condition resulting in death)			hock,				one day
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P.0	that the de led by the e detached		Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use conti	ribute to the cause of death?
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3	To the Hospital or Attend within 24 hours efter death To the Funerel Director; completely filled in by the	Me	29b. Signature and title of certifier	0		29c. Licens	se number		•	d (Month, Day, Year)
	5		Ver mai	the one	>	D5	0748	,	Jept.	29,2005
			30. Name and address of person who co							
	3		7et Wei Chan MD 31. Date filed (Month, Day, Year)	8600 O1	d Georgeto	xun Rd,	Bethes of	a MA	RYLAN	0 20814
	St Regist	ate rar	nct 0 3 20	05 Breeze	, J. P.					

GASTON, SOFHONIA 0752

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 26 2005 7:45 P M **Physician** Gallo Ana Leonor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 19000 Bloomfield Road Olnev If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or I Country) June 29, 1954 El Salvador Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Hours Days **Funeral** 51 Months 1 ☐ M 2 🔼 F 217-04-2826 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show itam 27 ia marked other than "natural", or Itama 23a or 28a-f show other traumatic avant, the Medical Examirar must be notified at 1 ☐ Yes 2 No MD Montgomery Gaithersburg Directo 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20882 El Salvador 6430 Stream Valley Way by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 XYes 2 No Specify: El Salvadorian Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ramona Gallo Virgilio Gonzalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6430 Stream Valley Way, Gaithersburg, MD 20882 vant: If itam 2) Juan A. Enamorado / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State September 30, 2005 Gate Of Heavenery permit. Page Department of importent: If any injury or once. Silver Spring, MD 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service tricensee Deer Park Drive, Gaithersburg, MD 20877 23. Panil to the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, them failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic Colon Cancer Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, 1 say, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No certificate or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence examiner' Hospital: 1 ☐ Yes 2 ♣ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? funeral After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attandin within 24 hours after death.

To the Funaral Director; Aft 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 27, 2005 D51916 Tornera 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay, M.D., 11140 Rockville Pike #348, Rockville, MD 20852 32) Registrar's Signature 31. Date filed (Month, Day, Year) State 03 Registrar

			For State Registrar	State of Ma	ryland	•	artmen rtificate			and M		Reg. No.	005	333	
ı	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month	Day	Year	3. Time of Do	
	/Medic		Jerry Godo. 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		Septemb		2005 ounty of Deat	- / - ' 	
	Exami	iei	Johns Hopkins Bay		Cent	er		timo,							
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					,		10d. Inside City	Limits
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	or 28	Jirec	10e. Street and Number	•			10f. Zip					_	n of What Co	untry?	
	s 23a	rall	404 Mt. Vernon A			10.1		2111		-i-0 (C-			JSA . Race - Ame	ion Indian	
21215-0036	4 within 72 hours after death with the Maryland liene. Tthen "naturel", or Items 23a or 28e-1 show the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? MXYes 2 N If Yes, Give Year or Dates:		Ì	was Deced f Yes, spec 1 ☐ Yes		spanic Ong n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, White		
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סר	0 0		20a. Method of Disposition 1 Burial 2 XCremation 3		ce	metery, cren	natory or o	ther place	·		-2005				
Baltimore,			* 4 □Donation 5 □ Other (Speci 21 Signature of Fune al Service Lice		Met	ro Cr					Home, F		lmore,	МП	
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E B		Con									1 Yes	2 No	death? 1 ☐ Yes	2 X No	
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		1	For State Registrar	State of M	laryland		artment <i>tificate</i>			and Me		jiene		33	3 9	99
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Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra		21. Signature of Fureral Service Licensee								ert E. I Bowie				Ome	;
г			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that cause cause on each	ed the death. line.	Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arr	est,		Interva	cimate I Betwo and D	en
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υor	ng Phy ter thi		27. Manner of Death	28a. Date of In (Month, D		8b. Time of	28	Bc. Injury Work			d. Describe ho					
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ш	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	ai Ce	29a. Certifier 1 Certifying Physic	ien: To the bes	st of my knowl	edge, deatl	n occurred a	at the time	e, date an	d place, an	d due to the ca	ause(s)	and manner	as stated.		
	ne Hoanne Fui	Medicai	(Check only 2 Medicel Examine one)	r: On the basis and manner s	of examinationstated.	n and/or in	vestigation,	in my op	inion, deat	th occurred	at the time, d	ate and	place, and o	lue to the ca	ıse(s)	
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70	Sta Registi		31. Date filed (Month, Day, Year)	128	strar's Signatu	re K	book	م								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			d December 1	State of Ma				of Death		Reg. No.	005	33400
//	ysici Vledio amir	cal	Decedent's Name (First, Middle, La William 4e. Facility Name (If not institution, giv Beverly Health C.	Leroy e street and number)		Gro	ove, Sr	4b. City, Town,	2. Date of Dat	er 6,	Year 2005 7 unty of Death	3. Time of Death
₀Fun Dire	ctor		5. Social Security Number 6. S		(In yrs. la	st birthday) Yrs.	If Under 1 Ye Months De		Hrs. 8. Date of B	Wash Wash Way, Year) 1911	g. Birthpla Gounty Maryl:	ce (State or Foreigi and
e Maryland	lified at	ctor	10a. State 10b. County MD Washingt			Town or Loca	ation				100	I. Inside City Limits
ath with the	wat be no	rai Dire	10e. Street end Number 18011 Putter Driv				10f. Zip Code 21740			10g. Citizen	of What Country	1?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23e or 28e-f show	Examiner	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		If Y	as Decedent of res, specify C		(Specify Yes or Nuerto Rican, etc.)		Race - American Black, White, etc cify: Whit	.
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at Depertment of Health and Mental Hygiene.	the Medical	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) Unknown	ucation de completed) College (1-4or 5+	')	16a. Deceder (Give kii life. DC		cupation ne during most of ired)	working		Business/Indus	
ryland ould be filed Mental Hyg	atic event,	To Be C	17. Father's Name (First, Middle, Last) Phillip E. Grove	- A				Ellen		e, Maiden Surr	name)	
e, Mar	ther traum		19a. Informant's Name/Relationship (7) Catherine L. Grove 20a. Method of Disposition			18011	Putter	Drive,	Rural Route Numb Hagerstov	m, MD	21740	
Itimor It. Pages Itment of Ite	o ao canda		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		thsbur	ion (Name of tory or other p g Crema	atory	Date 10/8/200		n-City or Town	
Ba Pem Depe	any a		21. Signature of Funeral Service Licens S. Mark S.	m		160	01 Penr	nsylvania	Rest Have a Ave., H	agerst		pel 21742
Physici /Medic Examir	cal ner	_	23a. Part1. Enter the disease, or come shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)	Con	ge.	o hiv	e H		- Per		Or	proximate perval Between nset and Death
requires that the death certificate be executed seen signed by the attending physician and should be detached for use as the bringlightenest		Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du		s a consequer		re			16	flar.
P.O. Box nat the death cert d by the attending		by Physician/	Part II. Other significent conditions con	d.	not resultir	ng in the unde	rlying cause g	iven in Part I.				ceuse of death?
lecords, P.O. Boy law requires that the death or las been signed by the attend 2.2 should be detached for use		Completed by P							24a. Was	Yes 2∟ No an autopsy rmed?	availab	autopsy findings ble prior to etion of cause
Vital Rec			25. Was case referred to medical						101		1 □ Ye	
6	H	0	examiner?	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye		b. Time of Injury	28c. Inju	her: 4 Nursing	eath (Check only o Home 5 - Residence of 28d. Describe h	lence 6 🗆 O		
UIVISION To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	Specify)				28f. Location (S City or Tow	n, State)		·
o the Host vithin 24 ho o the Fune ompletely fi	Modioo		29a. Certifier (Check only one) 1	icien: To the best of m ler: On the basis of exa and manner stated	ammanom	dge, death occ and/or investi	gation, in my a	opinion, death occ	curred at the time, o	date and place	nanner as stated , and due to the ed (Month, Day,	cause(s)
F ≥ F 8	_		Manger O. Name and address of person who co	g fra	h	a) (Type Br'-			5 Vel-	10-	7-05	i ⊎ar)
	State	3	MAW 2 A A. 11. Date filed (Month, Day, Year)	32. Registrar's	AP	1. 36	8 n	rier St	vel-	Herge	vstain	MAD

			State of Maryland 1- State RegistrarAmend Item #5 Per FH G848					giene Reg. No.	005	33401
	Physici	an	1. Decedent's Name (First, Middle, Last)			GAHS	2. Date of De. Month Octobe	Day	Year 2065	3. Time of Death 4:55 AM
hij popis	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death			County of Deat	h
			The Johns Hopkins Hospital			10YC CI		h	O. Ried	nalaga (Stata or Esmiras
	Funeral Director		5.390/al 330/rity/8004r 6. Sex 1 M 20 F 6.8	Yrs. Months	Days	Hours Min.	8. Date of Birt (Month, Da 6/3/1	937	Co	nplace (State or Foreign untry) [aryland
	lend wo		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location						10d. Inside City Limits
	h the Marylend r 28a-f show	tor	MD. Harford		Ja	rrettsv	ille			1 ☐ Yes 2 XNo
	th the	Olrec	10e. Street and Number	10f. Zip	Code			-	en of What Co	-
	s 23s	rail	3321 North Furnace Road	S 13 Was Doord	ant of Hi	21084	acity Vas or No		ited S	
	iter de	Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No			ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)		Black, White	
215-0036	within 72 hours after death with the Marylend iene. Than "naturel", or Items 23e or 28e-f show the Madical Examiner must be notified at	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2	X) No	Specify:		3	Specify:	<i>T</i> hite
Ċ	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)		k done d	during most of work	ing	16b. Kin	d of Business/	Industry
	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT us)			Nursi	ng
N	E ST E	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden S		
Maryland	should be nd Mental marked o	To B	William Robert A:	rdison		Ros	_	Mae	ī	Smith
lar)	2 2 2 2		19a. Informant's Name/Relationship (Type, Print)	Later and the second						(ip Code) 21161
	s 1 and f Health item 27 other tr		Amy L. DiGiacinto/Daughte: 20a. Method of Disposition 20b. P				White		L Mar ation - City or	
n o	00			lace of Disposition (Name emetery, crematory or of			10/05			Maryland
_	F 6 3	-	21. Signatura of Funeral Service Licersee			ss of Facility Ja				
ñ	Depermit. Depert Import any inj		11. Blackden Furty -			rtz & S				
П			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not enter the mode	e of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
ij.	Physician /Medical			agenous le	uke	emia				months
	Examiner		Due to (or as a consequ	uence of):						
		Jer	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence oly.						
p	ecuted ind transii	Examin	that initiated events c.							
60,	icate be executed physicien and s the burial-transit		Due to (or as a consequ	uence or):						
68760,		edical	d							
Вох	death certif e ettending ed for use as	M/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal		egnancy			23	3d. Date of deli	· ·
	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 28 No 9 □ Unknown 1 □ Ves 1 28 No 9 □ Unknown						Month	Day Year
P. O.	The law requires that the de ate hes been signed by the e page 2 should be detached f	Ph)	Part II. Other significant conditions contributing to death but not resi	ulting in the underlying ca	ause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
Division of Vital Records,	quires n sign lld be	d by					10	∕es 2 🕱	No 3⊟Pr	obably 4 Unknown
O O	aw require is been si 2 should b	Completed					24a. Was		24b. Were au	topsy findings available completion of cause of
ž	The lav	E O						rmed?	death?	2 No
Vita V	Physiclan: Th r this certificate rel director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deal				
ō	Phys this rel di	. To	1 Yes 2 No 1 No Indignition 2 Department 1 No Inpatient 2 Department 2 No Injury 28a. Date of Injury	ER/Outpatient 3 DC 28b. Time of 2	8c. Injun	4 Nursing no	ome 5 Resident			cify)
on	Attending I ir death. ector: After by the funer	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury M		k? Yes 2 □ No				
Vis	or Attended efter death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory	, office		28f. Location (. City or To		Number or Ru	iral Route Number.
Ω	oital or urs efte oral Dir iled in	Cer								
	To the Hospitel or At within 24 hours efter or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.							
	To the To the Comp	Me	29b. Signature and title of certifier			e number			signed (Monti	
			Den sencript moderine resi		(ES	- 000		octob	u 6,2	005
	15		30. Name and address of person who completed cause of death (Item DEVI JENGUPTA. USO NUFTH WO		BA	NTMOR	E, MD 2	212 %	7	
	Sta	te	31. Date filed (Month, Day, Year) OCT 1 4 2005	iture freeho			, -			
	Regist	ar	OCT 1 4 2005	P. Comment						

		For State	State of M	laryland	•	artment of H		nd Mental Hy		005	33402
Physic	ian	Registrar 1. Decedent's Name (First, Middle		TNG				2. Date of Do Month	eath Day	Year	3. Time of Death
/Medi Exami	ical	4a. Facility Name (If not institution	AYVION HUG(a, give street and number			4b. City, Town, or	Location of	SEP Death	19 4c. C	2005 County of Death	8:09 P M
		NATIONAL NAV				BETH	ESDA	4 Hrs 0 Date of Bi		MONTGOM	
Funeral Director		5. Social Security Number 686-07-5145	6. Sex 7. A 1 □ XM 2 □ F	ge (In yrs. Ia	Yrs.	Months Days 7 4	Hours	Min. 8. Date of Bi (Month, D. Jan • 2	3, Year)	005 M	nplace (State or Foreign untry)
/land		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
se Mary Ba-1 sh	ctor		e Arundel	Gi	len B	urnie					1 XYes 2 □ No
with the	Funeral Director	10e. Street and Number 8039 Crainmo	nt Drivo			10f. Zip Code 2106	1			en of What Cou	
death	nera	11. Marital Status	12. Was Deceden Armed Forces		3. 13.			n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Amer Black, White	
IIIG Z I Z I 35-UU30 be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Modical Examinar mast be multiled at	by Fu	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced		No		1 ☐ Yes 21☑ No	Specify:	, dono i nodin, oto.,	1	Specify:	
72 hours natural', o		15. Deceden (Specify only highes	's Education		(Give	dent's Usual Occupa kind of work done o	lurina most d	of working	16b. Kind	Bla of Business/li	
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d be filed antal Hygi ced other c evant, II	Be Co	17. Father's Name (First, Middle,	Last)			None	18. Mother	s Name (First, Middle			
aryiand ZIZI should be filed within nd Mental Hygiene, marked other than umatic evant, the Mi	To	Terrance Hug			405 14-35			nyia Rush or Rura/ Route Numb		T	'- C- 4-1
10 S P P P P		19a. Informant's Name/Relations Keonyia Hugo		r	803	9 Crain n Eurnie	\mathtt{nont}	Drive	er, City or	10 wπ, State, Zi	p Code)
OTC, IVI	H	20a. Method of Disposition 1		20b. Pla	ace of Dispo	esition (Name of matory or other place	9)	Date	20c. Loca	ation - City or T	own, State
DAILLINOT Dermit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (S21. Signature of Funeral Service	oecify)	Mar		d Vetera		9/26/05 em•			am, Md.
Depa Depa Impo any is		Danice a	dward	1				Hodges			F.H. Md.20746
		23a. 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. line.							Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aRENA	L FAII							
Examiner	П	Sequentially list conditions				ECROSIS					
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	ence of):						
6 / 6U, tale be executed ohysician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	s a conseque	ence of):						
cate be exphysician the buria	edical		d	<u>.</u>							
death certifical	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy			23	d. Date of deliv	
The Colds, F.O. BOX 08/ The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Year
s that the de	by Ph	Part II. Other significant condition	ons contributing to death	but not resul	lting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
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nec he law e has b ige 2 sl	Completed								psy prmed?	prior to co death?	opsy findings available empletion of cause of
	Be Co	25. Was case referred to medical					26. Place o	1 ☐ Yes of Death (Check only o	2X No	1 🗆 Yes	2 No
OI VICA Physician: this certific ral director,	2	examiner? 1 Yes 2X No 27. Manner of Death	Hospital: 1 Nnpat		R/Outpatien		4 LI I I I I I I	sing Home 5 Resi			fy)
Sing After fune	ation:	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig		ay Year)	Injury	Work	.?`` (es 2 □ No		non injury	oocanoa	
or Atte	Certificati	3 Suicide 6 Could in determine	ined 288. Place of it	iury - At hon tc. (Specify)	me, larm, str	eet, lactory, office		28f. Location (City or To		Number or Run	al Route Number,
To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fun			g Physicien: To the bes Exeminer: On the basis								
the H thin 24 tha F	Medical	29b. Signature and title of certifie	and manner s	tated.		29c. License		occurred at the time,		signed (Month,	
To vitt		> Wes	an (2			0101	.05790.	5 (VA)	09		2005
(2)		30. Name and address of person EDWIN C. DOE		death (Item :	23а) (Туре,			NAVAL MED MD 20889-		CENTER	
	ate	31. Date filed (Month, Day, Year)		trar's Signatu	Some				-		
Regist	उद्या	001 03 20	NO A CONTROL	a Vindo	Tet Mark	w					

			1- For State of Maryland / Department of Health and Certificate of Death		2005	33403
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		ELIZABETH V. HUTCHINSON		er 27, 200	5 11:05 a ^M
	Examin		.4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Di		4c. County of Death	
			Collington Episcopal Life Care Center Mitchellville		Prince Ge	
	Funeral		Months Days Hours N	Ain. (Month, Day, Y	'ear) Coui	**
	Director		158-22-4592 102 rrs. Usual Residence of Decedent	Jan. J,	1903 Ken	tucky
	yland Nor		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	a-fall	ctor	Maryland Prince George's Mitchellville			1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number 10f. Zip Code	10g	g. Citizen of What Cour	ntry?
	ath w	rai	10450 Lottsford Road 20721		U.S.A. 14. Race - Americ	an Indian
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or flems 23a or 28a-f show raumatic event, the Madical Examerant Demotified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Picture of Sarvey States of Dates: 1 Yes 2 No Specify:	r (Specify 1 es of No- uerto Rican, etc.)	Black, White,	etc.
5-0036	2 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	warking 16	b. Kind of Business/In	dustry
215	thin 7 e.	ηpie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	working		
2	ed wii	Cou	2 House Wife		Own Home	
gug	be fill htal H od oth	Be		Name (First, Middle, Ma	iiden Sumame)	
Maryland 2121	d Mer marke matic	2	Nelson Prewitt Van Meter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	oeth Willis Rural Boute Number C	City or Town, State, Zio	Codel 00050
Ma	d 2 s Ith an 27 is trau		Mrs. Ann Elsbree - Daughter 10401 Grosvenor Place			
ē,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natur any injury or other traumatic event, It e Musical any four.		20a. Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or To	
E O	Page: lent o nt: If		1 Buria 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 9	/29/2005 A	lexandria.	Virginia
Baltimore,	permit. Departmitimportal		21. Signature of Foneral Service Licensee 22. Name and Address of Facility	Basch's Fune	eral Home,	P.A.
<u>m</u>	89 = 88		oleut 1 / ay 4739 Baltimore A			20781
	Physician [°]		23a. Par 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as care shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		t.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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90,	ate be executed obysician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):			
8760,	cate b physic the b	dicai	d			
). Box 6	e death certifica he attending phe ed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the pas N 2 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delive Month	ery Day Year
P.0	hat the		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
Records,	w requires that the de been signed by the should be detached	ted by	Hypmasico		2 No 3 Prob	
al Rec	The lavite has	Completed by		24a. Was an autopsy performe	prior to co	psy findings available impletion of cause of
Vita	iding Physician: Th th. : After this certificate funeral director, pag	Be	examiner Userital: Other	Death (Check only one)	es 6 DOther (Seasif	.1
of	Physic ruthis aral di	. To	2 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		//
O	Attending r death. ector: After	tior	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	ne Hospit 24 hours ne Funera sletely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the companient of the comp			
	To the To the comp	Ž	29b. Signature and title of certifier 29c. License number 947663	29d	Date signed (Month,	Day, Year)
R	(12))	29b. Signature and title of certifier 29c. License number 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	216 Boin	i, mo	20716
	Sta Registi		OCT 0 3 2005			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 33404 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month JANE BECKER HOPKINS September 28 2005 10:53P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🔀 F Hours Min 87 Director 1917 577-10-1821 Dec.5, New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Modical Exercipant be notified at 10d. Inside City Limits 1 ▼ Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15100 Interlachen Drive, #906 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. All Saints Episcopal Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Church permit. Pages 1 and 2 should be lift
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other treumatic event
ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Becker ပ္ Marguerite Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herb C. Hopkins, III/Son 2146 Glencourse Lane, Reston, Virginia 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 10/4/2005 Brentwood, Maryland 21. Signature of Funeral Service Licenses HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tentre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction Minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician ician/Medicai the as IF FEMALE: nse. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 0 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 4 Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. detached Physi 9 Unknown ል Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ <u>Hypertension</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed History of Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 SER/Outpatient 3 DOA SI. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury death. investigation M 1 ☐ Yes 2 ☐ No after death 2 Accident 3 🗀 Suicide 6 Could not be determined n 24 hours after de ne Funeral Directo bletely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier ompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 D-43202September 29, 2005

DHMH 17 Rev 1/2001

State

Registrar

C. Ozanne-Blankfardus, M.D., 3305 North Leisure World Blvd, Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32 Registrar's Signature

31. Date filed (Month, Day, Year)

03

State of Maryland / Department of Health and Mental Hygie () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 4:45 PM eptember 27,200s JOHN LEROY HAMLETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan tim HOSpital If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1⊠M 2□F 75 College Park MD Director 579-34-0201 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Eventral remains to notified at 1 Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 13323 Tamworth Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Korean If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specif African-American Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates: War Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Administration 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental Finance of Mental Finance Catherine Eva Brooks Charles Leroy Hamlett ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
important: if Item 27 is
any injury or other tree 8853 Papillon Drive, Ellicott City, MD 21043 Ouida Freeman, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory10-03-2005 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Emm The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic **Physician** disease or condition resulting in death) /Medical Examiner Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed use as the burial-transi Due to (or as a consequence of) nding physician Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, sign be 1 Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed Obstructive Sleep Apnea 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 No 1 ☐ Yes Physicien: Be (25. Was case referred to medical director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Hospitel or Attending 1 Natural 5 Pending er death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Dirsc 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd, Baltimore, MD 21239 Kanumuru ,5601

Registrar

DHMH 17 Rev 1/2001

State

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State of Maryland / Department of Health and Mental Hygier 05

33406

		4	For State Registrar	Otate of marytan	Ce	rtificate	of Deat	h		ig. No.	33400
6 26	DI	7	1. Decedent's Name (First, Middle, Las	t)	· · · · · ·			2.	Date of Deati Month	h Day Year	3. Time of Death
	Physicia /Medic	al		ick, Jr.					tober	1 2005	6:10 a M
	Examin	_	4a. Facility Name (If not institution, give	street and number)			vn, or Locatio	n of Death		4c. County of Dea	ith
		& .	13825 Wayside Court	ax 7. Age (In yrs.	in at hinth da.	Clarks () If Under 1		er 24 Hrs. 8	Date of Birth	Howard	dhalana (Ctata as Caraina
- Medi	Funeral Director		5. Social Security Number 578–40–7182 Usual Residence of Decedent	D M 2□ F 83	Yrs.		ays Hours	s Min.	(Month, Day,	Year)	rthplace (State or Foreign ountry) sylvania
	yland		10a. State 10b. County	10c. Cit	ty, Town or l	ocation		····			10d. Inside City Limits
	a-f sl	ctor	Maryland Howa	ard (Clarksv	ille					1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip Co	ede		10	0g. Citizen of What C	ountry?
	23a		13825 Wayside Court			210				USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13	. Was Deceden If Yes, specify	t of Hispanic (Cuban, Mexic	Origin? (Specif can, Puerto Ric	y Yes or No- can, etc.)	14. Race - Am Black, Wh	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Itema 23a or 28a-f show ent, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎛 Widowed 4 ☐ Divorced	1 ∰Yes 2 □ No If Yes, Give WW Year or Dates:	[I	1 ☐ Yes 2🏧	No Speci	ify:		Specify:	White
ر ک	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de com <i>pleted)</i>	(Giv	edent's Usual C	tone during m	ost of working		16b. Kind of Busines:	s/Industry
7	ithin and	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life.	DO NOT use	etired)				
	i filed within the Hygiene. other then	S	17. Father's Name (First, Middle, Last)	4	Aerona	autical E	-	ther's Name //	First Middle A	F.A.A. Maiden Sumame)	
Maryland	m U S	o Be	Peter Hallick					Anna Poch			
2	2 should be and Mental ie marked (eumatic ev	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (S	treet and Num	nber or Rural F	Route Number,	City or Town, State,	Zip Code)
S	nd 2 a		Renee H. Walton/ Dau	ghter	1382	5 Wayside	Court,	Clarksvi	lle, MD	21029	
<u>6</u>	T Here		20a. Method of Disposition	20b. I	Place of Disc	osition (Name ematory or other	of	Oct. Dat		20c. Location - City o	r Town, State
Ë	A Page		1 ☐ Burial 2 ③ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		opolita	an Cremat	ory	2005	I	Mexandria, M	<i>Virg</i> inia
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 ie marked any injury or other treumatic expres.		21. Signature of Funeral Service Licen	500		rancis J 500 Unive				inc oring, MD 209	901
	-50		23a. Part1. Enter the disease, or compshock, or leart failure. List only	plications that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Congestive Hear	rt Fail	ıre					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec							
ľ	Examiner		Sequentially list conditions	b. Ischemic Cardio		ıy					
	Pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
	and errans	Examiner	that initiated events resulting in death) Last	c	guence of):						
68760,	tificate be executed ig physicien and as the burial-transit			d							
9	tificating phy	Medical									
.O. Box	death cer e attendir id for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	al death 3	☐Ectopic preg ☐ Other (spec				23d. Date of de Month	olivery Day Year
٥.	that the the the the the the the the the th		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying cau	se given in Pa	irt I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires n sign	ed by							1 □ Ye	os 2□No 3□F	robably 4 CUnknown
Records,	The law requires that the ate has been signed by th bage 2 should be detache	Completed							24a. Was ar		utopsy findings available completion of cause of
	The lav ate has page 2	mo:							perform	ned? death? 2√√No 1 ☐ Ye	
Ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					ace of Death (
<u></u>	Physician: r this certifica ral director, I	၉	1 Yes 2 XNo	Hospital: 1 Inpatient 2						ence 6 Other (Sp	ecify)
Division of Vital	ding F th. After funer	Certification:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	M 280	Injury at Work? 1 Yes 2		d. Describe no	w injury occurred	
Visi	i or Attending after death. Director: Afte I in by the fune	ifica	3 Suicide 6 Could not b			street, factory, o	ffice	28	f. Location (St. City or Town	reet and Number or F	Rural Route Number,
	taior rs afte aiDir ed in	Cert		Dandarig, C.C. (Open						,,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		nysician: To the best of my kn niner: On the basis of examin and manner stated.							
	ro the Mithin Fo the Somple	Me	29b. Signature and title of certifier	1			icense numb	ør .	2	9d. Date signed (Mor	
	2.1		Non le No	enricon, in	UD		21115			October 2,	2005
	170)		30. Name and address of person who Lee R. Pennington, I	completed cause of death (Ite	m 23a) (Typ I Road,	e, Print) Bethesda	, MD 208	317			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	82. Registrar's Sign	ature	ules					

05-06613 John Hough

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien $_{900}$ 33407 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** R. John Hough 2005 September 28, 18:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8203 Palmer Road Middletown Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F Yrs. 47 Director 216-74-3284 June 30, 1958 Morocco Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits worde! ir then "neturel", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Point of Rocks Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1736 Canal Run Drive 21777 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Real Estate marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fit Iment of Health and Mental H tant: If Item 27 is marked ott Be Joan Marceron John Hugo Hough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Point of Rocks, Maryland 21777 Beth Ann Hough / Wife 1736 Canal Run Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State October 2005 permit. Page Department Important: ff eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Frederick Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cutte **Physician** Wou /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to minimate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transi Due to (or as a consequence of) Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE ٩ 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Division 5 Pending investigation 1 Natural cot wants death. n 24 hours after death.

• Funerel Director: A pletely filled in by the fu 1 9/28/05 Found 18/64 2 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 6 8203 Pal Hospital an 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 O.C.M.E. September 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 115

33408

				C	ertificate	of Dea	th		Reg. No.	00	00400
Physician		1. Decedent's Name (First, Middle, La	-					2. Date of De Month	eath Day	Year	3. Time of Death
/Medical			Hershal Hil	1.1				Sept.		2005	2 p.m.
Examiner	-	4a. Facility Name (If not institution, given	ve street and number)			4b. City	Town, or Lo	cation of Deal	th 4c. Count	ty of Deeth	
		21 Mason Dixo	on Dr.				ing S	un	C	ecil	
uneral	1		Sex 7. Age (In 1 ☐ M 2 ☐ F	yrs. last birthda	/) If Under 1 Y Months D	rear If Un Pays Hou	der 24 Hrs. rs Min.	8. Date of Bi (Month, De	rth	9. Birthp	place (State or Foreign
rector		131200012	10 M 20 F	76 Yrs.	,	,		10-3	1-28	Ball	timore MI
*	- 1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or I	ocation						
event, the Medical Examiner must be notified at Be Completed by Funeral Director		MD Cecil			sing S	Zun				11	Od. Inside City Limits
be notified Director	[1 ☐ Yes 2 💢 No
	5	10e. Street and Number			10f. Zip Co				10g. Citizen of		ntry?
	5	21 Mason Dixo				21911			US	A	
finer must	5	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13	. Was Decedent If Yes, specify	of Hispanic Cuban, Mex	Origin? (Spe icen, Puerto	ecify Yes or No Rican, etc.))- 14. Ra Bia	ce - America	an Indian, etc.
Ş F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☐						
20			Year or Dates:47 -							^{∱y:} Whit	
Completed	_	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual O le kind of work d DO NOT use re	ccupation one during n	nost of worki	ng	16b. Kind of E	lusiness/Ind	dustry
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B	í	John Herst	•						, Maiden Sumai	ne)	
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		19a. Informant's Name/Relationship (ling Address (St						
		Larry D. Hil			2 Ashv		Rd.	ТТ			
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<u> </u>		4 ☐ Donation 5 ☐ Other (Specif	(y) [V	Vest No	ttingh	am C	em. 1	0-3-5	Color	a, MI	D
5 9	1	21. Signature of Fu stal Service Licer	nsee/////	2	22. Name and A	ddress of Fa					
any Injury or other traumatic event, the Med once. To Be Comple		7 Miller 1	MINI				E	dward	L. Co	llins	5
	1	23a. Part1. End the Isease, or com shock, or heart failure. List only	plications to t caused the	death. Do not er	nter the mode of	dying, such	as cardiac o	r respiratory a	ord, P	A 193	363 Approximate
cian	1	shock, or neart failure. List only	one ceuse on each line.								Intervel Between Onset and Death
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ner		disease or condition resulting in death)	a								
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Examiner	١.	Cognoptially list conditions	b	to (or as a conse	valuance, of):						
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n/Medicai		Sequentially list conditions, I any, leading to immediate seuse. Enter Underlying Cause (Disease or injury hat initiated events esulling in death) i ast	C. Due 1	o (or es a conse	anoboo of:						
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		art II. Other eignificent conditions o	antribution to double but a se				ī	1			
Physicia		art ii. Other eignincent conditions o	ontributing to death but not	resulting in the t	undenying cause	e given in Pe	π ι.				the cause of death?
by Pi							•	10	Yee 2□ No	3 ☐ Proba	ably 4 ∑ Unknown
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Completed								perfo	an autopsy med?	avai	ilable prior to
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B	1	Was case referred to medical examiner?	11 - 1 - 1				ece of Death	(Check only o	ne)		
ဥ	_	1 ☐ Yes 2 to No		2 ☐ ER/Outpatie	III SU DOA		Nursing Hom	e 5 🗷 Resid	lence 6 □Oth	er (Specify))
Certification:	2	7. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Dey Yea	r) 28b. Time of Injury	of 28c. I	njury at Work?	2	8d. Describe h	now injury occur	red	
at		2 ☐ Accident investigation			М	1 ☐ Yes 2	□No				
		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, st ec <i>ify)</i>	reet, factory, offi	ce	2	Bf. Location (S City or Ton	Street and Numb	er or Rural	Route Number,
Ö									., 0		
cal	2	9a. Certifier	ysicien: To the best of my	knowledge, deat	h occurred et the	e time, date	and place, a	nd due to the	ause(s) and ma	inner as sta	ted.
comparary filled in by the funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physicia	L	5.15)	niner: On the basis of exame and manner stated.	miation and/or in	vesugation, in m	ıy opinion, d	eath occurre	u at the time, (pate and place,	and due to t	rne cause(s)
E S	2	9b. Signature and title of certifier	//		29c. Lic	ense numbe	r		29d. Date signe	d (Month, D	ay, Year)
11		>	NEWAR		HO	1550	71		9/2	n/m	
1/2,	3	0. Name and address of person who o	completed cause of death (Item 23a) (Type		110	00		110	10)	
		Dr. Naylor,				Depos	sit, 1	MD			
State	3	1 Date filed (Month Day Vess)									
egistrar		1. Date filed (Month, DOCT) 0	2003 ^{2. Registar's Si}	w D	More						
	•				-						

4b. City, Town, or Location of Death

4a. Facility Name (If not institution, give street and number)

3. Time of Death

6:20 PM

Year

2005

4c. County of Death

*	Physician
	/Medical
1	Examiner

		de .	University of Maryl	and Medical	Center	Baltin				/A
	Funeral		5. Social Security Number 6. Security Number		rs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	Sirthplace (State or Foreign Country)
*	Director		212 70 3535	^{1M 2} ₹ 5	O Yrs.			OCT.29,1	954 VI	RGINIA
	<u> </u>		Usuel Residence of Decedent							T
	ylan Nor		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
:	Mar - Ba	Director	MARYLAND ANNE ARUN	DET. RI	VA					1 □ Yes 2 No
	288 F	rec	10e. Street and Number		- 411	10f. Zip Code		10	g. Citizen of What (Country?
	with a		DOV 150 512 DODECT	L DOAD		21140		T TN	THEE CHA	mec
	s 23	Funerai	BOX 158-513 FOREST	12. Was Decedent Ever in	11.6 12	. Was Decedent of H	ienanic Origin? (Sr		NITED STA	nencan Indian.
	ar de	S	T. Markar States	Armed Forces?	10.3.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wi	
36	aff of	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21 No If Yes, Give		1 ☐ Yes 2√2 No	Specify:		Specify:	Total
21215-0036	72 hours after death with the Maryland neture!; or items 23a or 28a-f ehow dical Examiner must be notified at	9		Year or Dates:						ITE
Ŋ	2 should be filed within 72 hours after death with the Marylan and Manthal Hygiene. Is marked other than "neturel", or items 23a or 28a-f show aumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>	(Giv	edent's Usual Occup e kind of work done	during most of worl	king 1	6b. Kind of Busines	ss/tnaustry
2	within ene. than	ig l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	")			
7	filed w Hygier ther th	Ö	12	0	HOME	MAKER			HOME	
Maryland	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ie (First, Middle, Ma	aiden Sumame)	
<u>a</u>	ould b Menta arked atice	2	JONES ATKINS				JANE LO	UISE MICK	ŒLSON	
2	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mai	ling Address (Street	and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
ž	d 2 Ith a 27 is		RONALD A. HIBBARD	(HUSBAND)	BOX 1	158-513 FC	ACE TO RES	D BIJA N	nD. 21140	
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	1	20a. Method of Disposition		. Place of Disp	position (Name of		The same of the sa	Oc. Location - City	or Town, State
ō	m O		1 ☐ Burial 2X Cremation 3 ☐ F		cemetery, cre	ematory or other place	1			
Ξ.	Pa ant: ury		4 Donation 5 Other (Specify)	KA	LAS CRI	EMATORY	10-1	0-05 E	EDGEWATER	,MD.
Baltimore,	permit. Page Department (Important: If eny injury or once.		21. Signature of Funeral Service Licens	00	4	22. Name and Addre	ss of Facility GEO	RGE P. KA	LAS FUNE	RAT, HOME
m	20E 2 9		10 alle			2973 SOLON	ONS ISLA	ND ROAD	EDGEWATE	R,MD,21037
À	A 98		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de						Approximate Interval Between
	Disconintan		Immediate Cause (Final							Onset and Death
}	Physician /Medical		diseese or condition resulting in death)	Brainsten						
*	Examiner			Due to (or as a cons						
2. La		_	S uentially list conditions. if any, leading to immediate	<u>Thrombosis</u>		silar Arto	ery			
	D #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons			147.7.20			
	death certificate be executed e attending physicien and id for use as the burial-transit	Examine	that initiated events	Coil Occlus		Cerebral	Aneurysn	L		
ó	en a	Ä	resulting in death) Last	Due to (or as a cons	sequence of):					
68760,	ysici ysici	ca		d						
89	ifica g ph as th	ed								
ŏ	din din	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		_			23d. Date of d	delivery
m	atte	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 🛣 Unknown	9□ Unknown						
a.	uires that the death cer i signed by the attendin Id be detached for use	by Physician/Medical	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Ś	rest igne		, and an an an an an an an an an an an an an	·····						Probably 4 Unknown
ord	J _ ~	ted						1 103	, 2010 00	
Recor	The law requate has been page 2 shou	Complete						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
æ	The lav	E						perform	ed? th	?
a		Ü	25. Was case referred to medical	-ATT			OC Piero of Dee	, , ,	1	es 2□No
Vital	Physician: this certific ral director,	00	examiner?	Hospitat: X	Пери	ant 3 DOA Oth	or	th Check only one		
ō	Phys rat di	2	1 th Yes 2 □ No □ □ 27. Manner of Death		ER/Outpatie	BIIL 30 DOA	4 🗀 Hursing II	ome 5 Resider 28d. Describe hov	nce 6 Other (S)	
	ng fle ine	o	1_Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	unk Wor				Complications
.2	Attending r death. ector: After oy the fune	ati	2XAccident investigation	9/27/2005			Yes 2X No	of electi	ve thera	peutic proce-
Division	er de rects	ti i	3 Suicide 6 Could not be determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, s ecify)	street, factory, office		28f. Location (Stre City or Town.	State) 77 C	Rural Route Numberdure Greene St.
Ö	s afti	Certification:		Medical Cer				Baltimore	MD S	· orecite pr.
	nour:		29a. Certifier 1☐ Certifying Phy	sician: To the best of my	knowledge de:	ath occurred at the tir	ne date and place	and due to the car	use(s) and manner	as stated.
	Hc 24 Fu etely	edical	(Chack only one) Medical Exam	iner: On the basis of examand manner stated.	ination and/or	investigation, in my o	pinion, death occu	rred at the time, da	le and place, and d	lue to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	₩	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)
	₩ S № 0		larel L	Hellow	IAA A	0.0	C.M.E.	00	tober 09	2005
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DHMH 17 Rev 1/2001

State Registrar AN w.A 111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date fited (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month DORIS V. HANLON 9, 2005 October 5:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 961 Stable Ct. Davidsonville Anne Arunde] If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 ☐ M 2 X F Director Yrs. 097-01-6609 89 9-26-16 New York Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mental Hygiene. snt: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Madical Examinatin usine recitional. 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 961 Stable Ct. 21035 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation

Air kind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th **Homemaker** Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John G. Janson Eva Mary Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Carlton/ Daughter 961 Stable Ct., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or `4 ☐ Donation 5 ☐ Other (Specify) 10-16-05 Kalas Crematory Edgewater, MD 21. Signatur Furer Svice Vicensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Lementia Zheimes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 100

9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 🕏 No Other: ျ 4 - Nursing Home 5 Pesidence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Tescribe how injury occurred 1 Natural
2 Accident To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No in by the 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nd title of certifier 29b ignature 29d. Date signed (Month, Day, Year) 12059166 10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric C. Marcalus, M.D. 3169 Braverton Rd., Edgewater, MD 21037 31. Date filed (Month, 1 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygien $\geqslant 0.05$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Yeer 2:30 PM CHARLES FREDERICK HUGHES OCTOBER 8, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner WALDORF

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5141 AMBERJACK COURT CHARLES 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral X**M 2□ F 88 Director 183-09-5526 MAR.5,1917 PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 XNo MARYLAND CHARLES WALDORF Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5141 AMBERJACK 20603 COURT U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:WW II 1 ☐ Never Mam'ed 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, importent: If item 27 is marked other than "n any injury or other treumatic event, Its Medi PINE RICHLAND Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ SCHOOL DISTRICT TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WELLS HUGHES JENNIE HARER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES HUGHES-SON 5141 AMBERJACK CT., WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN CREMATORY 10-10-05 ALEXANDRIA, VIRGINIA 21. Signature of Eutheral Service Licenses 27. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sestine **Physician** HEGST /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Š Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 (Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed peen Was an autopsy performed?
Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has page 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ (No 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1. Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (pt 9 0 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 4 2005

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			1 - For State Registrar	State of M	arylan	d / Depa	artmen rtificat	t of H e of L	ealth a	and Mei		ene g. No.	005	331	+12
	0		1. Decedent's Name (First, Middle, I	.ast)						2.	Date of Death	n Day	Vans	3. Tîme	of Death
	Physic /Medi		Annie Jean Hilt							Se	Month ptember	r 27	7, 200	9:50) A ^M
	Examir		4a. Facility Name (If not institution, g						Location	of Death		4c. (County of Dea	ath	
			Shady Grove Adve					vil1				1	ntgomen	ry	
	Funeral			Sex 7. Ag		last birthday)	If Under Months	1 Year Days	If Under Hours	Min. 8.	Date of Birth (Month, Day, 19, 16,	Year)	9. Bi	rthplace (State ountry)	or Foreign
	Director		228-44-0001 Usual Residence of Decedent	10 111 2021	89	Yrs.				Ju	ly 16,	191	l6 Viı	rginia	
	and and		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside	City Limits
	f sho	ō	MD Montgom	erv	Gai	thersb	uro								s 2XNo
	288 288	rec	10e. Street and Number		our		10f. Zip	Code			10	n Citiz	en of What C	Country?	
	3a or	iO	16824 Westbourne	Terrace				878				J	U.S.A	•	
	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "naturel", or Items 23a or 28e-f show termatic event, the Worlas Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.			spanic Ori	rigin? (Specify in, Puerto Ric	y Yes or No-	1-	4. Race - Am		
9	or Ite		1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Yes 2 1	No						an, etc.)		Black, Whi		
03	rel', o	iby	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□ Yes 2	2 A No	Specify:	:		3	Specify: W	iite	
21215-0036	72 h	Completed by	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usua kind of wor	I Occupa	ition Jurina mas	st of working	1	6b. Kin	d of Business	s/Industry	
21	ithin Pan.	μ	Elementary/Secondary (0-12)	College (1-4or	5+)					st of working					
2	led w lygier her ti	S	12			Anima	1 Car	etak					oital		
<u>n</u>	be fill tal H d otl	Be	17. Father's Name (First, Middle, La.	•							irst, Middle, M		,		
7/8	Mer Marke Marke	ြို	Harvy George Ta			Processor .		,			la Hene				
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natur. eny injury or other treumatic event, the Middeal once.		19a. Informant's Name/Relationship Joann Sittinger								oute Number,				70
e)	1 and 1 and 1 am 27 3 m 27 ther t		20a. Method of Disposition	- Daughter	20h P	lace of Dispo			ne re	Date	, Gaith				/8
Baltimore,	Sec = 10		1 ☐ Burial 2X Cremation 3		0	emetery, crer	natory or o	ther place			_		ation - City or		
ŧΪ	t. Pa rtmer rtent rjury		'4 □Donation 5 □ Other (Spec		Pt.	Linco	In Cr	emat	ory	0/02/2	.005 Br	rent	wood,	Maryla	nd
Bal	Depa mpo any i		21. Signature of Funeral Service Lic	ensee	1						le Trib				
				eanly	4						Rockvil		Maryl	,	
			23a. Part . Enter the disease, or co shock, or heart failure. List on	ly one cause on each l	ne death	i. Do not ent	er the mode	e or dying	, such as	cardiac or re	spiratory arres	SI,		Approxim Interval B Onset and	ate etween d Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_aPneumor	ia									4 Day	
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	ted nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury	250 10 (51 40	a consoqu	201108 017.									
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×	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	псу						23	3d. Date of de	livon	
Вох	atter I for u	ciar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pre					1	Month	Day	Year
o.	that the dead by the detached	isku	1	9□ Unknown				,,				-			
م.	requires that the een signed by th hould be detache		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the ur	nderlying ca	ause give	n in Part I.	ı.	23e. Did toba	acco us	e contribute to	o the cause of	death?
ds	quires n sign	d by	Dementia								1 🗆 Yes	2 🗆	No 3∏P	robably 4X	Unknown
Records,	w requir been si should	Completed									24a. Was an		24h Were a	utopsy finding	s available
Re	The law rate has be page 2 sh	ш									autopsy perform		prior to death?	completion of	cause of
		O O	25. Was case referred to medical						no Diseas	4 D 4 h (O	1 ☐ Yes 2. heck only one	No	1 🗆 Yes	2 🔯 No	
>	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 X Inpatio	ent 2 □ 1	ER/Outpatien	t 3 DO	A Othe			5 Residen		Clother (Con		
			27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		Bc. Injury Work	at		. Describe how			city)	_
on	Attending r death. sctor: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigati		y rear)	Injury	M		? ′es 2 🔲 I	No					
Division	or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not	d 289. Place of in	ury - At ho	me, farm, str	eet, factory	, office		28f.	Location (Stre		Number or Ri	ural Route Nu	mber,
=	el or A s after il Dire	Certification:	4 Homicide	building, ef	с. (Бреспу	")					City or Town,	State)			
	Hospitel 24 hours a Funerel I stely filled	aic	29a. Certifier 1 🛣 Certifying F	hysician: To the best	of my know	wledge, death	occurred a	at the time	e, date an	nd place, and	due to the cau	ıse(s) a	nd manner as	stated.	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Expone)	aminer: On the basis of and manner st	r examinat	ion and/or inv	estigation,	în my opi	inion, deal	ith occurred a	at the time, dat	e and p	lace, and due	to the cause	(s)
	To the To the Complet	Me	29b. Signature and title of certifier	1		NAT	29c.	License	number		290	d. Date	signed (Mont	h, Day, Year)	
	4		1/W			1 11	4	D58	3681		Se	pter	mber 2	7, 2005	5
•	1		30. Name and address of person wh	o completed cause of c	leath (Item	23а) (Туре,	Print)								
_			Jude Alexander, M					ive,	Rock	ville,	Mary1	and	20850		
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registr	ar's Signat	ture 1000	Les I								

221.12

			State of Maryland / Do	Spartificate of L		Reg. No.) 33413
	0		Decedent's Name (First, Middle, Last)	70711770410 07 1	2. Dete of I	Death	3. Time of Death
200	Physici /Medi		Bernard Hall		\$epter	mber 25 20	505 6:00AM
	Examir		4a Fecility Neme (If not institution, give street end number)		b. City, Town, or Location of De	ath 4c. County of De	eeth
			Heritage Harbour Health & Reh		Annapolis	Anne Ai	
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. lest birth 218-12-9034 Usuel Residence of Decedent	Months Davs	Hours Min. (Month.)	9. E Day, Yeer) 24 1917 Ma	Birthplace (State or Foreign Country) Bryland
	/lend		10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	Man	اغ	Maryland Anne Arundel West	River			1 ☐ Yes 2 🌠 No
	or 28	ire.	10e. Street end Number	10f. Zip Code		10g. Citizen of What	Country?
	eth w	ra	5259 Sudley Rd.	20778		USA	
21215-0020	parmit. Peges 1 and 2 should be filad within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show any fujury or other traumatic event, the Medical Examinist must be notified at page.	t by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cube 1 ☐ Yes 2 No	ispenic Origin? (Specify Yes or I n, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Ar Black, Wi Specify: B]	
5	natu	etec	15. Decedent's Education 16e. D (Specify only highest grade completed)	ecedent's Usual Occupa Give kind of work done d ife. DO NOT use retired,	ation during most of working	16b. Kind of Busines	ss/Industry
12	withir ene. then	To Be Completed	Elementary/Secondary (0-12) College (1-40r 5+)	steel Worl		Bob Poss	Steel Co.
9	Hygid Hygid Sther	ပိ	17. Father's Neme (First, Middle, Last)	reel MOII	18. Mother's Name (First, Midd		Steel Co.
Maryland	fentel fentel ked c	0	Frederick Hall		Charity John	nson	
ary	should by and by			failing Address (Street a	and Number or Rurel Route Num	nber, City or Town, State	e, Zip Code)
Σ.	and 2 patth n 27 l	1			. N.E. Washir	igton D.C.	. 20019
Baltimore,	Peges 1 ment of He ant: If Iten lury or oth		cemetery,	isposition (Name of crematory or other place ion Church	h 9-29-0	20c. Location - City of Lothian	, Md.
Ball	parmit Dapard Import any in		21. Signature of Funeral Service Licensee Harry 7. Feese MOC 482		s of Facility e & Sons Mor St. Annapol:		A. 1401
			23a. Pert1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			arrest,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Le My-	eLomA		Onset and Death
	be is	ılner	b. Due to (or as a co	ANCE!	R.		† ; !
ó,	tificate be axecuted g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	N / A:			
68760,	tificate b g physic as the b	-	that initiated events resulting in death) Last	sequence of):			
Box	th car andin r usa	Physician/N	d				1
0	s daa ha att	sici	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	en in Part I. 23b. Die	d tobacco use contribu	He to the cause of death?
О.	s that the ned by t e datach	by Phy	HenAto CheZIH		1[Yes 2040 3	Probably 4 ☐ Unknown
Records,	The law requires that the death cartificate be assected are has been signed by the attending physicien and page 2 should be datached for use as the burial-transit	Completed b	()		24a. Wa	is an autopsy 24b formed?	Were autopsy findings available prior to completion of cause of death?
œ =	The late hg	Com			10	Yes 2 PNo	1 ☐ Yes 2 ☐ No
/ita	olan: ertific ector,	Be	25. Was case referred to predical examiner?		26. Place of Death (Check only	one)	
5	hysto this c el dire	2		atient 3 DOA Othe	4 Wursing Home 5 □ Res		pecify)
Division of Vital	Attending Physician: ir deeth. sector: After this certifici by the funerel director,	Certification:	1 □Natural 5 □ Pending (Month, Dey Year) Inju	ry Work M 1 □ Y	/es 2 □ No	e how injury occurred	
DIX	Ital or Ature attar or el Directiled in by	Certifi	4 Homicide determined 288. Place of Injury - At nome, farm building, etc. (Specify)		City or To	(Street and Number or I own, Stete)	
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funerel Director: Atter this certificate has complately filled in by the funerel director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the besis of examinetion end/o	r investigation, in my op	inion, death occurred at the time	e, date and place, and du	ue to the cause(s)
	5 <u>1</u> 5 0	-	29b. Signeture and title of certifier	29c. License	~ ~ () /	29d. Date signed (Mor	nth, Day, Year)
			Leich office /0; MI		8685.	//	4/0)
			30. Name end address of person who completed cause of deeth (Item 23e) (Ty 31. Date filed (Month, Dify, Year) 32. Red Strar's Signature	pe, Print) N/U · BCV	D. SHITE 326	Siliste	MB. 20901.
	Sta * Registr		31. Date filed (Month, Dlfy, Year) SEP 2 8 2005	Smart "			

			1 - State of M Registrar	Maryland / Depa Ce	artment of F rtificate of			2005	33414
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Karl S. Hershey				2. Date of Death Month Sept 29	Day Year 2005	3. Time of Death 0710 M
	Examin		4a. Facility Name (If not institution, give street and number Calvert Memorial Host	pital	4b. City, Town, o Prince	r Location of Death Frederi	ck	4c County of Death Calvert	
	Funeral Director		5. Social Security Number 6. Sex 7. A	Nge (In yrs. last birthday) 84 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug 16	(ear) 9. Birthp Cour 1921 New	place (State or Foreign ntry) York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			1	10d, Inside City Limits
	Maryli -f eho	Į į	Maryland Calvert	Lusby					1 ☐ Yes 2 ☐ X 90
	th the	Directo	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Cour	ntry?
	ath wi		12370 Algonquin Trail		20657			United St	
980	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other then "naturel", or items 23a or 28a-f ehow imatic event, the Medical Examinar mant be notified at	by Funerai	11. Maritaf Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Marrie	s?]No	Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes 2 ☒ No	fispanic Origin? (Sp an, Mexican, Puerto Specify:	Decity Yes or No- Dican, etc.)	14. Race - Americ Black, White, Specify: V	
o o	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	king 16	Sb. Kind of Business/In	dustry
2121	d within 72 giene. er then "nai	Completed	Elementary/Secondary (0-12) Coffege (1-4or	music	DO NOT use retired Cian/ US	S Army B	and	U.S. Army	7
Maryland 21215-0036	ould be filed v Mental Hygie wrked other i	To Be C	17. Father's Name (First, Middle, Last) Charles D. Hershey			18. Mother's Nam Hele	ena Zapp	iden Sumame) Y	
	es 1 and 2 should b of Health and Ments litem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type, Print) Louise E. Hershey - W.					City or Town, State, Zip y Marylar	
altimore,	permit. Pages 1 a Department of He Importent: If Item eny Injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo competery, cre Arlingto	osition (Name of matory or other plac on Natio	onct 11 chal Cem		nc. Location - City or To rlington	own, Sfate Virginia
Balt	permit. Departr Importe eny Inj		21. Signature of Funeral Service Licensee		2. Name and Addre			uneral Ho rt Republ	12.3
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each			-	or respiratory arres	t,	Approximate Interval Between Onset and Death
)	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death) Due to (or a	as a consequence of):	that	talling.			
	Examiner		Sequentially fist conditions bb.	many A	son O	ISI-CI			
	nsit	niner	framy, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a conseque ce of):	ch ha	6)			
, 0,	icate be executed physicien and s the burial-transit	I Examin	that initiated events c. resulting in death) Last Due to (or a	as a con equence of):	1 = 11 < 5.10				
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P.O. Box	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Physician/M		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of defive Month	ery Day Year
	w requires that the de been signed by the e should be detached f	by Ph	Part II. Other significant conditions contributing to death	0.		ven in Part f.		cco use confribute to the	
ord	requir	eted	Typicturis, Wa-1	Insulper	NCY			2 No 3 Prob	
Division of Vital Records,	i: The law icate has b r, page 2 s	Completed					24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
<u> </u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	itient 2 ER/Outpatie	ot 3 DOA Ott	oc.	th (Check only one)	ce 6 □Other (Specif	60
n of	ng Phys ter this neral di	-	27. Manner of Death 28a. Dafe of In			y at	28d. Describe how		<u>"</u>
siol	tendir death. tor: Af the fu	catic	2 Accident investigation		M 1 🗆	Yes 2 □No	001		10
<u>∑</u>	al or Al s after o i Direc d in by	Certification:	determined 200. Flace of	injury - At home, farm, st etc. (Specify)	reet, factory, office		City or Town,	et and Number or Rura State)	ii Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besigned Medical Examiner: On the basis and manner	of examination and/or in	th occurred at the time	me, date and place, ppinion, death occur	, and due to the cau rred at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of confine		29c. Licens	se number	7	1. Date signed (Month,	Day, Year)
,			30. Name and address of person who completed cause of	f death (ftem 23a) (Type	Print)	U0 1 1 1	do EDOS	16105	ruland
	0+1		M. Mathur, MD 110 Hosp 31. Date filed (Month, Day, Year) 32. Regis	sfrats Signature			ce rkede	stick Ma	TATUIN
1	Sta Registi		SEP 3 0 2005	Glower &	bouter				

			State of Marylai 1 - Samend Item#9 per FH G849 11/	nd / Depa /01/05 e/	artment of He	ealth and M <i>eath</i>	ental Hy	giene ()	5 33415
*	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	/Medic	al	Ismet A. Facility Name (If not institution, give street and number)	Hijab	4b. City, Town, or L	ocation of Death	10	4c. County of E	S 08:55 A.M
	LAGITATI	ις i	Socred Heart Hospital			erland		Alles	
	Funeral Director	ÿ	5. Social Security Number 6. Sex 7. Age (In yrs 214-90-6326 1 M 2 KF 84	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt Month, Day Jul 7,	1921	Birthplace (State or Foreign Country alestine ISTAC
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. C MD Allegany	City, Town or Lo					10d. Inside City Limits 1 Yes 2- No
	with the	i Direc	10e. Street and Number 342 National Highway		10f. Zip Code	1502		10g. Citizen of Wha	
936	72 hours after death with the Maryland naturel', or itema 23e or 28e-f ehow lited Exiculting at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hisp f Yes, specify Cuban, X	panic Origin? (Spe	ocify Yes or No- Rican, etc.)	14. Race - /	American Indian, Vhite, etc.
21215-0036	Jene. Jene. r then "naturel", c	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of workii	ng	16b. Kind of Busin	
212	filed within Hygiene. Ither then "	Comp	Elementary/Secondary (0-12) College (1-4or 5+)	Home	maker			own home	9
land	d la b	To Be	17. Father's Name (First, Middle, Last) Amen Halaby		1	18. Mother's Name Raaesa	(First, Middle, Halak	Maiden Surname) D y	
Maryland	nd 2 shou alth and M 27 ie mar r traumal		19a. Informant's Name/Relationship (Type, Print) Alaa Hijab son	19b. Mailin 161	ng Address (Street an 13 McMulle	en Hwy,	Route Number	ar, City or Town, Sta	MD 21502
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Itam 27 ie marke eny injury or other traumatic: 9008.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Place of Dispo cemetery, cred estlawn M	sition (Name of matory or other place) emorial Gard	lens	ate 10/5/2005	20c. Location - City LaVale	y or Town, State
Balti	permit. Departm Imports eny Inju		21. Signature of Funeral Service Licensed	1 22	NamStaffelli 108 Virgi			rland, MD 21	502
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O. Box 6	death certii e attending nd for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregrant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P	signed d be de	þ	Part Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause given	in Part I.	23e. Did to		te to the cause of death? Probably 4 □Unknown
al Record	The ete h page	Completed	HYPOTHYROID.SIM		*		1 Tyes	prior deat 2 No 1	e autopsy findings available to completion of cause of h? Yes 2□ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ✓ No Hospital: rompatient 2 □	☐ ER/Outpatien	Othor	26. Place of Death		ne) dence 6 □Other (Specify)
on of	ing After une	on: T	27. Manner of Death 1 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at 2		now injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	or Attendition for death irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc.)	home, farm, str		es 2 No	28f. Location (S City or Tow	Street and Number o	r Rural Route Number,
7	pit ours fille	Medical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the best of my kn 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death	n occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	and due to the o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier		29c. License r	number		29d. Date signed (M	fonth, Day, Year)
	B		Protection of a second control of the second	om 22a) (To-	Reint)	31875		OCT	5 2005
	<u> </u>		30. Name and address of person who completed cause of death (Ite	SCTOR		#308 (umbe	rland,	MD 21502
	Sta Registi		31. Date filed (Month, Day, Year) 32. Jegistrar's Sign	nature -	arte				

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1	Physici	an	1. Decedent's Name (First, Middle,								Date of Dea Month	Dav	Year	3. Time of Death	
	/Medic	al	Ezra Robert 4a. Facility Name (If not institution,		el		4h Cih	Tour or	Location of		October		2005 County of Dea	1019 A M	
~	Examin	er	· · · · · · · · · · · · · · · · · · ·	County Ho		1	4D. City,		agerst			1	Washing		
i/m	Funeral	e Company		i. Sex 7. /	Age (In yrs.	iast birthday)	If Under Months	1 Year_	Il Under 2 Hours		8. Date of Birth (Month, Day	h Voarl	9. Bir	thplace (State or Foreign	
	Director		220-52-1690	1 ∑ M 2□F	55	Yrs.	Months	Days	Hours		Dec.16,	1949		yland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Mary -1 • hc	tor	Md. Wash	nington		H	lagers	stown	ı					1 ☐ Yes 2 🛣 No	
	n the	Director	10e. Street and Number				10f. Zip					10g. Citiz	zen of What Co	ountry?	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, the Mudical Examinar must be positified at	alD	22139 Jugtown Ro	1.				21	742				U.S.A		
	er dea	Funeral	11. Marital Status	12. Was Deceder Armed Force	5?		Was Deced If Yes, spec	dent of Hi offy Cuba	spanic Orig n, Mexican,	gin? (Spe Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marner 3 ☐ Widowed 4 ※ Divorced	d 1 □ Yes 2 2 If Yes, Give Year or Dates	_		1 🗆 Yes	2 X) No	Specify:				Specify:	White	
Ş	2 hou	ted	15. Decedent's	Education		16a. Dece						16b. Kir	nd of Business		
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2	ygien ygien ver th	Con	10			Equi	.pmen	t Ope	erator				onstruc	ction	
Maryland 21215-0036	be fill H off	Be	17. Father's Name (First, Middle, La								(First, Middle, eda B. 1				
2	hould d Mei mark	은	Henry Holt: 19a. Informant's Name/Relationship			19h Mailir	na Address	(Street a			I Route Numbe			Zin Code)	
Z	Ith and 2 s		Louise Sheedy (S:			P.O.	Box	68 B	oonsbo	oro,	Md. 217	13	rown, State,	LIP COGE)	
ē,	s 1 er		20a. Method of Disposition			Place of Dispo emetery, crer	sition (Nar	ne of	e) i		ate	20c. Lo	cation - City or	Town, State	
altimore,	Page ne∩t c ant: if ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			retown			· .	oct. 20		Ca	vetown	,Md.	
alt	permit. Pages 1 end 2 should be Department of Health and Menta Important: If item 27 is marked eny Injury or other traumatic e- <u>ones</u> .		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury												
8	80559		John Joseph January J.L. Davis Funeral Home Smithsburg, Md. 21783												
*		_	shock, or heart failure. List or Immediate Cause (Final	nry one cause on each	line.							rest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. META	ST/AT		UNG	CA	Run	om.	A				
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	D #	ner	Sequentially list conditions												
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8760,	cate be execu ohysician and the burial-tra	alE		00810 (01	13 a conseq	dence or,									
687	ficate physis the	edical		d.											
	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregna	incy	ne . (i)					2	3d. Date of de	livery	
œ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant 9□Unknown	at time of d		Ectopic pi Other (sp						Month	Day Year	
o.	that the de led by the a detached t	Phys	9 Unknown												
Ś	S 5 6	۾	Part II. Other significant condition											o the cause of death?	
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Sec	has t	Completed	CARCONIC OBSTRE	OCPIVE /	UMO	WAK T	PIS	C7750	£		24a. Was a autop perfor	sy	24b. Were at prior to death?	utopsy lindings available completion of cause of	
<u>a</u>			イイクビエイENSION 25. Was case referred to medicat								1 ☐ Yes	2 1 No		2 □ No	
₹	Attanding Physician: r death. sctor: After this certifics by the funeral director, i	To Be	examiner?	Hospital:	ntient 2□	ER/Outpatier	nt 3 🗆 DC	Othe			n <i>(Check only or</i> me 5 ☐ Resid		Other (See	10164)	
ס	g Physical control	n:T	27. Manner of Death	28a. Date of Ir (Month, I		28b. Time o		28c. Injun Worl			28d. Describe h			cny)	
Ö	andin sath. or: Af	atlo	1 Natural 5 Pending 2 Accident Investiga	tion	, , ou,	injury	М		Yes 2 1	No					
Division of Vital Records, P.O. Box	br Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	288. Place of	Injury - At he etc. (Specif	ome, larm, str	eet, factor	y, office			281. Location (S City or Tow			ural Route Number,	
	pital ours eret Deret Dilled i														
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certific completely filled in by the funeral director.	dica	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and during the death occurred at the time, date and during the death occurred at the time, date and during the death occurred at the date and during the dat								aria aue to the d ed at the time, d	ause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
	To the Mithin To the	Me	29b. Signature and title of certifier	290	c. License	e number			29d. Date	e signed (Moni	h, Day, Year)				
	0		Mathan	Mubbly, n	M		D62562 10-0				08-05				
	18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADNAY HUBBLY, WASHINGTON COUNTY NOSPITAL 251 E-ANTIETAM STREET HAGERSTOWN MARYLAND 21740												
	10			STREET	HA	4 C-RSTI	NWO	m	ARYL	AN	D' 217	40			
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4	2005	strar's Signa	B A	perke								

			1- State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygier	_000
	e'		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Robert Hunt Jr	•	oct. 1,	^{Day} 2005 Year 9:51 A M
	Examir		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death Ft. Washingto		4c. County of Death Prince Gaorges
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} F 1×10^{-9} M 2×10^{-9} M	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 28	
	פ		Usual Residence of Decedent		1100.20	
	Marylar 8-f show	tor	10a. State 10b. County 10c. City, Town or Beltsv. Marylan Prince Georges			10d. Inside City Limits 1. ☑ Yes 2 ☐ No
	or 28	ire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w	rai [11590 Old Baltimore Pike	20705		United States
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2. XNo Specify:	pecify Yes or No- po Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	within 72 ho ene. than "natur he Medical.	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	king 16b	b. Kind of Business/Industry
	filed with Hyglen ther the			reprenuer		Retail
and	ould be fii Mental H larked ott	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
Maryland	should ind Men ind marke	은	Robert Hunt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Edmo iling Address (Street and Number or Ru	nia C. D	ay
Ma	id 2 s Ith an 27 is r traur			00 Old Baltimore		
-	t and Health tem 27 other tr			position (Name of	Date 20c	Location - City or Town State
JOL	Pages nent of I int: If it		1 ★Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Home	and	08/05 p _a	ertlow, Va.
Baltimore,	permit. I Departm Importar any injur		21 Signature Funeral Segre Licensee	22. Name and Address of Facility 57 Snead Funeral Ho	32 Georg washi	
			23a. Part 1. Enter the disease of complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pn ysician		Immediate Cause (Final disease or condition	Le Cardina	northy	Onset and Death
	/Medical		resulting in death) Due (or is a consequence of):	ve Carolory	10 may	years
	Examiner		Sequentially list conditions, b. hypertensi	00	-	years.
	sit sit	Examiner	any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	- 1		·
_	and I-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):	po211		yeo-15
60,	icate be executed physician and s the burial-transit	aE	300 (0 (0) 00 0 00).			
68760,	ficate phys s the	edicai	d			
.O. Box	law requires that the death certifices been signed by the ettending I s should be detached for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
0	that the de led by the e detached t	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobaco	co use contribute to the cause of death?
Records,	w requires that been signed b should be deta				1 Tes	
	The law ate hes by page 2 sh	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
Vital	cian: artific actor,	Be (25. Was case referred to medical examiner?		th (Check only one)	
0	ing Physician: After this certific uneral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpat 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	of 28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how in	a 6
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	e)(s) and manner as stated. and place, and due to the cause(s)
	roth within Foth	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	. 7. 0		- Silary A. Washington	D32800 Read 11205 Ft W	0	ct. 3,2005
			30. Name and address of e on who completed cause of death tem 23a) (Type Hillory II Westington Litella, nostro	3000 AL 205 FL 11/	Shratan	DIENE CM
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 4 8005	Man new 17 W		

	1- For State of M	laryland / Departme <i>Certifica</i>	nt of Health and M te of Death	lental Hygien	とししつ	33418
Physician	1. Decedent's Name (First, Middle, Last)	- 1 1		2. Date of Death	ay Year	3. Time of Death
Physician /Medical	Koger	Ireland		September	29 2005	1425 PM
Examiner	4a. Facility Name (If not institution, give street and number St Agnes Hospita	1	y, Town, or Location of Death	4	Ic. County of Death None	
- Funeral	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday) If Und	er 1 Year If Under 24 Hrs.	8. Date of Birth	Q Right	place (State or Foreign
Director	521 28 6242 1 [™] M 2□F	80 Yrs. Months	s Days Hours Min.	Nov 15, 1	924 Col	orado
land	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location			1	Od. Inside City Limits
Mary Mary	MD Howard	Columbia				1 ☐ Yes 2 XNo
death with the Maryland me 23a or 28a-f show triviat be netitied at	10e. Street and Number		lip Code	10g. C	Citizen of What Cour	ntry?
ath w	6500 Freetown Road Unit 10		21044		Inited Sta	
of the death virther death virther death virtheme 23 discrete	11. Marital Status 1 ☐ Never Married 12. Was Deceden Armed Forces 1 ☐ Never Married 12. Was Deceden Armed Forces	? If Yes, sp	edent of Hispanic Origin? (Sp ecify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036 ours at	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	1 Yes	2 ☑ No Specify:		Specify: Wh	ite
21215-00 ed within 72 hour yejene. Syejene natur. It is malical it, in a malical Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Us (Give kind of w	rork done during most of work	ing 16b.	Kind of Business/Inc	dustry
within see.	Elementary/Secondary (0-12) College (1-4or	Physici		T	IC NOTE	
d 2 filed other ent, in	17. Father's Name (First, Middle, Last)	FIIVSICI		e (First, Middle, Maide	IS Navy en Sumame)	
Vian build be Mental mrked of attic ev	Gail Leonard Ireland		Eleanor	Staats		
Maryland 21215-0036 nd 2 should be filed within 72 hours all the and Mantal Hygiene. 27 is marked other than "naturel", or traumatic event, the Marical Exacul To Be Completed by F	19a. Informant's Name/Relationship (Type, Print)		ss (Street and Number or Run	-		Code)
Ce, N 1 and Health Am 27 ther t	Jill M. Ireland/Daughter 20a. Method of Disposition	20b. Place of Disposition (N	ale St. San An		78209 Location - City or To	own. State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-1 show any nigry or other traumatic event, the Medical Exaculation and once. To Be Completed by Funeral Director	1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from Stat	comotoni cromatoni or	other place)	k	,	
mit. Postme	21. Signature of Funeral Service Licensee		and Address of FacilityHar			
Demi	Dem Colhis- Wit		old Columbia P			
* * * * * * * * * * * * * * * * * * * *	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not enter the mo- line.	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	CVA				48 hours
Examiner	Due to (or a	s a consequence of):	VD			A Property
	Sequentially list conditions, flary, leading to immediate cause. Enter Underlying	s a consultation of):	V			7,000
D, executed in and ini-transit	Cause (Disease or injury that initiated events c. Due to (or a					
18760, cate be executed physician and it the burial-transit dical Examir	Due to (or a	s a consequence of):				
6876(ifficate be g physicia as the bur	d.					
OX 6	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	e of pregnancy 2 Fetal death 3 Ectopic	pregnancy		23d. Date of delive	,
P.O. Box 6 P.O. Box 6 nat the death certifi d by the attending letached for use as	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	at time of death 5 _ Other (s			Month	Day Year
		but not resulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
ords, requires the signer and be consigner to the signer and the s				1 Tyes	2 No 3 Prob	ably 4 2 Unknown
Vital Record vician: The law requir certificate has been s rector, page 2 should				24a. Was an	24b. Were auto	psy lindings available
Of Vital Recc of Physician: The law ra er this certificate has be eral director, page 2 sh n: To Be Complet				autopsy performed?	death?	mpletion of cause of
of Vita of Vita Physician: this certific	25. Was case referred to medical examiner?			h (Check only one)		
Of Of Physical directions and directions of the Physical directions of the	Till res 20040 Figuripa			me 5 Residence 28d. Describe how in		v)
Vision Vision Attending r death. sector: After by the fune	1 → Natural 5 Pending (Month, D	Jay Year) Injury M	28c. Injury at Work? 1 Tyes 2 No		,,	
Division of the following Particular of Attending Particular Start death. Solution of the funering the funering of the funering particular start of the funering par	3 Suicide 6 Could not be determined 28e. Place of light building,	njury - At home, larm, street, facto	ory, office	28f. Location (Street a City or Town, Sta		I Route Number,
Division To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the Medical Certifical					·	
the Hospi iin 24 hou the Funar pletely fill	29a. Certifier 12 Certifying Physician: To the bes (Check only 2 Medical Examiner: On the basis one) and manner:	of examination and/or investigation	d at the time, date and place, on, in my opinion, death occur	and due to the cause(red at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
To the within To the compl	29b. Signature and title of cert for	25	9c. License number		ate signed (Month,	
		$\overline{}$	73757	3 Se	ptember-	30,7005
(20)22	30. Name and address of person wo completed cause of	death (Item 23a) (Type, Print)	Beisterstown		1	
. 5	Sef Zilo-ell Mo 75 31. Date filed (Month, Day, Year) 32. Rais	Main St.	Keisterstown	~ MD	C1136	
State Registrar		ave B. Soul	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 33419 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 30, Year 2005 William Johnson 5:45 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery | ROCKVIIIE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 16, 1920 6. Sex 14 M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country)
 Hawaii 7. Age (In vrs. last birthday) 576-07-9030 85 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12905 Byefield Drive 20777 USA 12. Was Decedent Ever in U.S. Armed Forces? L Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: WWII Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Office Federal Government Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Johnson Helen Huch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Johnson/wife 12905 Byefield Drive Highland, Maryland 20777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State OctoBer 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 2005 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Obstructive Renal Disease resulting in death) Due to (or as a consequence of): Sequentially list conditions, any lacing transports cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pancreatitis, malnutrition 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, MD 20855 Charles Harrison M.D. 32. Raistrar's Signature 31. Date filed (Month 03

State Registrar

1241

Physician

/Medical

Examiner

Director

Completed by

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Funeral

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r than "natural", or Itama 23a or 28a-f ahow the Medical Examinar must be positied at

other than

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important; if item 27 is marked oth any linury or other traumatic avent soice.

Physician

/Medical

Examiner

attending physicien and for use as the burial-transit

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iractor: After this by the funeral of

filled in by

page 2:

The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Examiner

Physician/Medical

Completed by

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Certification: To

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death with the Maryland

Baltimore, Maryland 21215-0036

			State of Marylar State Registrar	•	artment of H rtificate of L		Re	g. No. UU	5 33420
	Physici	_	Decedent's Name (First, Middle, Last) Lillian M. Jon	200			2. Date of Death	er 30 20	3. Time of Death 005 5:50 P M
25	/Medic	al	4a. Facility Name (If not institution, give street and number)	ies	4b. City. Town, or	Location of Death	Septemb	4c. County of	
	Examin	er	Lorien Nursing Home		Mt. Ai				roll
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs 96	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 14,		9. Birthplace (State or Foreign Country) Nebraska
and	MC II		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
Mary	fied a	to	MD Howard	Ellico	ott City				1 ☐ Yes 2 X No
ith the	or 28	Oirec	10e. Street and Number		10f. Zip Code		10	0g. Citizen of Wh	,
ath w	23e	rai	5320 Dorsey Hall Drive Apt 309	10 12	21042		acify Vas or No-		States American Indian,
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in (Armed Forces? 1 □ Yes 2 ☒ No II Yes, Give Year or Dates:	1.3.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2⁄⁄⁄ No	Specify:	Rican, etc.)		White
21215-0036 od within 72 hours af	ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa	ation	ina	16b. Kind of Busi	
215 Tailed	Med A	Be Completed	Elementary/Secondary (0-12) Coltege (1-4or 5+)	life.	kind of work done of DO NOT use retired		,,,9		
121 ed	Hygier ther th	Co	12 17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name	e (First, Middle, A	Own Ho	
	ked of	To Be	Thomas Dolan			Alma Sto			
Maryland	traumat	-	19a. Informant's Name/Relationship (Type, Print) Joanne J. Honsberger/Daughter		ing Address (Street a				ate, Zip Code)
Baltimore,	t: If Item y or other		20a. Method of Disposition 20b. 1 ☐ Rurial 2 ☐ Cremation 3 ☑ Removal from State	cemetery, cre	osition (Name of ematory or other place	9)			ity or Town, State
Baltir	Departme Importan any injur		21. Signature of Funeral Service Licensee MO1	044 2	2. Name and Addres	ss of FacilityHar	ry H. Wi	tzke's I	Family FH Inc.
P	hysician		23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		iter the mode of dying			est,	Approximate Interval Between Onset and Death Comparison of the Co
	/Medical xaminer		Due to (or as a conse	quence of):	cardiar	escular	DITE	ASE	10 41
po	asit S	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):					
68760, ilicate be executed		cal	that inflated events resulting in death) Last	quence of):					
Box	led by the attending phy deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. II yes, outcome of pregration in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (<i>specify</i>)			23d. Date Mont	,
S, P	2 5 0	b	Part II. Dther significant conditions contributing to death but not re	sulting in the u	underlying cause give	en in Part I.			ute to the cause of death?
Rec	has b	Completed					24a. Was a autops perforr	ned? pri	ere autopsy findings available or to completion of cause of ath? Yes 212 No
	certificete	Be	25. Was case referred to medical examiner?		100	26. Place of Deat	h (Check only on	Θ)	
of Vita	this aldin	<u>٩</u>	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie		+ MINUISHING FIC	ome 5 Reside		· · · · · · · · · · · · · · · · · · ·
	After	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2□No	200. Describe no	W inquiry occurred	•
Division	after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, larm, si	treet, factory, office		28I. Location (St City or Town		or Rural Route Number,
	vihin 24 hours after To the Funerel Directory completely filled in b	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my kr	nowledge, dea	ith occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and man ate and place, ar	ner as stated. d due to the cause(s)
, F	withir To th comp	Me	29b. Signature and title of certilier		29c. Licens		2		(Month, Day, Year)
•			P HALL IND	am 22a) /Tur-		31912		Octobe	1, 2005
22	_			UPOSIV	mount	144, En	EDFRILL	,mD	21702
3	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 3 2005 32. Rostrar's Sign	nature A	faile				

State of Maryland / Department of Health and Mental Hygier 005

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			1 - State Registrar Certificate of Death	Reg. N		33421
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Di M	ate of Death	Day Year	3. Time of Death
	/Medic	al		ctober o	02 300	
- F	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death EASTON	4	4c. County of Death	int
0	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. D.	ate of Birth Month, Day, Yea	9. Birti	nplace (State or Foreign
7	Director		218-09-6455 88 NS. Jul	Ly 3, 1917		ryland
0.1	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
00.	Maryl f aho	tor	Maryland Caroline Denton			1 ☐ Yes 2 🙀 No
<u>_</u>	h the	lrec	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Co	untry?
Jonro	after death with the Maryland or iteme 23s or 28s-f ahow cultier from the molling at	Funeral Director	9810 Corkell Road 21629	Unit	ed State	s of America
5	er des	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	Yes or No- n, etc.)	14. Race - Amer Black, White	
) /	irs aft	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1942 − If Yes, Give 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify:		Specify:	casian
SO ∩ , 1	r2 hou	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/l	
0 2	ithin 7.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	_		
55	iled w Hygier ther th	Co	11 HS Grad Refrigeration Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First		e Cream (Company
JACK Maryland	d be f antal h	o Be	George Washington Jackson Emma Ri			
Y E	shoul nd Ma marl	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rou			ip Code)
1 / -	and 2 alth a 27 is		Frances A. Jackson Wife 9810 Corkell Road, De	enton,	Maryla	nd 21629
Baltimore	of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c.	Location - City or 1	Town, State
Ë	Pag tment tant: i		4 Donation 5 Other (Specify) Denton Cemetery 10/6/20	005 De	enton, I	Maryland
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examination at the notified at once.		21. Signature of Pineral Service Licensee 22. Name and Address of Facility Moore Funeral Home	e, P.A.	•	21629
		7	23a. Parl 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resc	treet.	Denton	Approximate
	Physician		snock, or near tailure. List only one cause on each line.	,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a			
	Examiner	L	Sequentially list conditions, b. Wosevsis			
	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
_	and and al-trar	Exan	Cause (Disease or injury that initiated events resulting in death) Last C. Acutu Julian Necos S Due to (or as a consequence of):			
68760,	rtificate be executed ng physician and nas the burial-transit		d			
		Medical	IF FEMALE:			
Вох	Attanding Physician: The law requires that the death ce cleath. sctor: After this certificate has been signed by the attendit by the funeral director, page 2 should be detached for use	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	}	23d. Date of deli-	very Day Year
P.O.	the de	Physician/	1 □ Pregnant at time of death 5 □ Other (specify)			,
م م	s that ned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
rds	aquire en sig ould b	ed b	Alzheimer's dementio	1 es	2 No 3 Pro	bably 4 Unknown
Division of Vital Records,	law re as be	Completed by	cerebrovagular accident	24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
<u>~</u>	ding Physician: The I h. After this certificate ha funeral director, page	Con	1	performed? I ☐ Yes 2 ☐ K	death? 1 ☐ Yes	2 □ No
Vita	dertifi certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No			
ō	Phys r this aral di	٦. 10	Pullingatient 2 EH/Outpatient 3 DOA 4 Nursing Home	5 Residence Describe how in		ify)
ion	nding ath. r: Afte e fune	atlor	1,⊄Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		,	
<u>ivis</u>	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ocation (Street a	and Number or Rui	ral Route Number,
۵	oital o urs aft arai Di	Cer				
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fo	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discovered at the time, date and place, and date and place, and date are the time, date and place, and date are the time, date and place, and date are the time, date and place, and date are the time, date and place, and date are the time, date are	lue to the cause(the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month	, Dey, Year)
	0		1/2000 Srm 1 MD D0059762	10	12105	
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	10 m 20 20 20 20 20 20 20 20 20 20 20 20 20		Haider Sorrar MD Easton, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Sta Registi		OCI 5 2005			

	1 - State Registrar	e (First, Middle, Last)			Certificate of	Dealli	2. Date of D	Reg. No eath		3. Time of
n	Loree	Burre		Jordan			Month Octobe:	r 7	y Year 2005	20:34
al er		If not institution, give s		JULUAN	4b. City, Town, o	r Location of Deat			. County of Dea	
		ide Drive				ake City			Cecil	
	5. Social Security N	1 1	7.Ag M2 X∏ XF	e (In yrs. last birt) 85 Y	Months Days	If Under 24 Hrs Hours Min.		av. Year)	l Go	thplace (State or ountry)
	254-26-1 Usual Residence of			05			верг.	10, 1	1920 Geo	orgia
	10a. State	10b. County		10c. City, Town						10d. Inside Cit
Director	Maryland	Cecil		Chesape	ake City					1 🗆 Yes
	10e. Street and Nu	mber side Drive			10f. Zip Code 21915				tizen of What Co ted Stat	-
era	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Was Decedent of H	lispanic Origin? (5	Specify Yes or N		14. Race - Ame	
Funeral		ried 2 Married	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes 2 💆 No	an, Mexican, Puer	to Rican, etc.)		Black, Whit	
o c	3 ☐ Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		TO Yes 2E3No	Specify:			Specify: Wh	hite
ete	(Spec	15. Decedent's Educify only highest grade	cation e completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	durina most of wa	orking	16b. K	and of Business	/Industry
Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+) Caf	eteria Atte	*		Scho	ool Syst	tem
ø		(First, Middle, Last)					me (First, Middle			
0	Carter	Burrel1				Minnie	Hopkins			
	19a. Informant's N	ame/Relationship (Ty	pe, Print)	19b.	Mailing Address (Street	and Number or R	ural Route Numi	ber, City o	or Town, State, 2	Zip Code)
	Linda N.		Daughte	-	Bayview Ro	ad, Che	sapeake			
	20a. Method of Dis 1 🔀 Burial 2	position □Cremation 3 □R	lemoval from State	cemeter)	Disposition (Name of , crematory or other place	ce) Oco	tber 14		ocation - City or	
		5 Other (Specify)		Mounta	inview Ceme 22. Name and Addre	tery 20	05	Mari	ietta, (Georgia
		uneral Service License	A = 0 =		Hicks Hom	e for Fu	nerals,	P.A.		
	23a. Part1. Enter t	the disease, or compli	ications that caused	d the death. Do n	ot enter the more of yer	Stockton	Street	E11	cton, MD	21921
	Immediate Cause	art failure. List only or	le cause on each in	110.		ig, suon as oar sa	o or respiratory	un out		Interval Retu
			Acuto M				o or respiratory	41.031		IIIfaiAgi DafA
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Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie (2) 15 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHNSON **Physician** Month Year 12:15 PM FRANCES October 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nonth, Days Hours Min. Sept. 18, 1935 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 233-52-1633 West Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Ia markad other than "natural", or Itams 23a or 28a-f ahow other traumatic event, I'ls Medical Examinar must be notillied at Director 1 ☐ Yes 2 🕅 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Maloney Road 21921 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3

Widowed 4 □ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7, in and Mental Hygiene. 7 Is marked other than "ns College (1-4or 5+) Elementary/Secondary (0-12) Cashier Retai1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dominic Paul Paletta Mary Cortez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health item 27 Terry L. Brooks/Daughter 88 Barksdale Court, Elkton, Maryland 21921 20b. Place of Disposition (Name of cometery, fromatory or other place)

Immaculate Conception

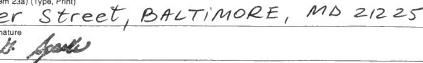
10, 2005 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ott once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Sign ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY years CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** COLON CANCER Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury burial-transit CHRONIC OBSTRUCTIVE PULM. DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician DIABETES Physician/Medical MELLITUS use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, CONGESTIVE HEART 1 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 €Inpatient 2 □ ER/Outpatient 3 □ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 CEBOTARU 29c. License number 29b. Signature and title of certifier VALERIU

Registrar

South Hanover 31. Date filed (Month, Day, Year) 0CT 1 4 2005 32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cetotary, MD



222745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33424 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day OCT. 6, 2005 MORRIS ALLEN JONES 4:30 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LAUREL REGIONAL HOSPITAL PRINCE GEORGE LAUREL MARYLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□ F 230-70-4783 54 Yrs. VIRGINIA **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ral, or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1. Yes 2 No MARYLAND ANNE ARUNDEL Directo LAUREL MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 CHERRY HILL LANE 20724 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Specify: BLACK 1 Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. NASA GODDARD Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER SUPERVISOR SPACE CENTER 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fi of Health and Mental F Item 27 Is marked ot JOSEPH JONES, SR. EMMA SMITH JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET JONES (WIFE) 104 CHERRY HILL LANE LAUREL MARYLAND 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department of Important: If any injury or MT.OLIVE CHURCH 10/9/05 4 □ Donation 5 □ Other (Specify) WICOMICO CH. VIRGINIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BERRY O. WADDY) 6784 MARYBALL ROAD LANCASTER VA. 22503 23a. Part 1. Enter the disease, or complications that caused the det th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final CARCINOMA OF PROSTATE Priysician METASTIC1 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions or injury Due to (or as a consequence of): Examiner executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician certificate be Physician/Medical the 28 ding IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELITUS SARCOIDOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen HYPOTHYORDISM NEUTROPENIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed? certificate RESPIRATORY FAILURE HYPOTENSION 1 ☐ Yes 2 🛛 No 1 Yes 2 X No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 5 Pending 1 XVatural hours after death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide ò filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Maryland

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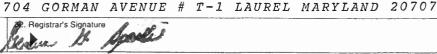
State Registrar R. G., BROJRAJ., M. D.

31. Date filed (Month, Day, Year)

OCT 1 4 2005

220 Lot ws

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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OCTOBER 6,2005

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			1 - For State Registrar	State of Ma	aryland / De	partmer ertifica			Mental Hy	/gienę́ Reg. No		33425	
	Physici /Medic		Decedent's Name (First, Middle, La Fannie Elizabeth	•					2. Date of D Month SEPTE		^y 30,2005	3. Time of Death 1:09P. M	
je.	Examir		4a. Facility Name (If not institution, giv	e street and number)		,		ocation of Death			. County of Death		
			703 FOREST DRIVE 5. Social Security Number 6. S	ev 7 An	e (In yrs. last birtho		ERSTO	WIN If Under 24 Hrs.	9 Data of B		ASHINGTO		
	Funeral Director			☐ M 2□XF	88 Yrs	Months		Hours Min.	8. Date of 8 (Month, D	4v, Year) 191	7 9. Birth	place (State or Foreign intry) WV	
	land w		10a. State 10b. County		10c. City, Town o	Location						10d. Inside City Limits	
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	or 28	Director	10e. Street and Number				p Code			10g. Cit	tizen of Whal Cou	ntry?	
	ath w		703 Forest Drive				740				JS		
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itama 23e or 28e-f ahow important: if item 27 is marked other than "natural", or itama 23e or 28e-f ahow hy Injury or other traumatic avent, tra Medical Exerting must be notified at ODGs.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕱! If Yes, Give Year or Dates:		3. Was Dece If Yes, spe 1 \(\sum \) Yes		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White Specify: Bla	, etc.	
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Maryland	12 shouth and Manager		19a. Informant's Name/Relationship (Richard Keats /	Туре, Print) Son	19b. M	ailing Address	s (Street ar	nd Number or Rur	al Route Numb	er, City o	or Town, State, Zij Stown, M	o Code) D 21742	
	s 1 end / Health tam 27 other tr	15	20a. Method of Disposition		20b. Place of Di	sposition (Na.	me of		Date	_	ocation - City or T		
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P.O. Box	Attending Physician: The law requires that the death certif or death. actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use an	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (sp					23d. Date of deliv Month	ery Day Year	
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Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	Completed							24a. Was auto perfe 1 X Yes	psy ormed?	prior to co	opsy findings available impletion of cause of 2 No	
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411	7		30. Name and address of person who		eath (Item 23a) (Ty								
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			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H	Health and Mo Death		giene 005	33426
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	Funeral		5. Social Security Number 6. S	ex 7 ^t . Age	(In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-05-1	Year) 9. B	irthplace (State or Foreign Country)
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	within 72 hours after death with the Maryland ene. then "naturel", or fems 23e or 28e-f show fre Medical Examinar must be notified at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	th wit		P.O. Box 193			2	25434		USA	
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lan	ild be lental ked ic ev	To B	Deskin Arthur	Kerns			Sarah	Ethel	Day	
Maryland	should be mad Not be mad Not be made Not b	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rural	Route Number	, City or Town, State,	Zip Code)
	and 2 valth i		Roland B. Kerns	r. (son)	HC-6	60 Box 18	-1 Paw Pa	w, WV 2	25434	
ore	of He		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □	Bemoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	(a) 10/1:		20c. Location - City of	r Town, State
altimore,	Pag ment: f ent: f		4 Donation 5 Other (Specify		Woodrow	Cemetery	10/1.	1/03	Paw Paw, V	W
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show any Injury or other traumatic event, tra Medical Examinar must be notified at once.		21. Shatur of Funeral Service Lice	3 ()	1	. Name and Addre	ss of Facility Mcl 270 Augus		eral Home	Inc.
	3.0		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused to	the death. Do not ent	er the mode of dyin	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between
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8760,	cate be executed physician and the burial-transit	dlcal		d						
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Division of Vital Records, P.O. Box	The taw requires that the death certificate has been signed by the attending trage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or death 5	Other (specify)				
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æ	he tav e has age 2:	E C		2011-22-77				autops	ned? death?	
ta	iclsn: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death	1 Yes 2		s 2 No
>	ysicls s cer direct	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	t 2 ☐ ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Home			acutu)
0	Attending Physicism: r death. ector: After this certifics by the funeral director, t	2	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Work	y at 28		w injury occurred	, , , , , , , , , , , , , , , , , , ,
<u>ö</u>	ath. rr: After re funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		Yes 2 □No			
<u>×is</u>	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	28	If. Location (Str. City or Town	reet and Number or F	lural Route Number,
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	To the Hospital or Attending Physicism: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	one) 29b. Signature and title of certification	and manner state	ed.	29c. License			9d. Date signed (Mon	
	N W L	_	250. Signature and title of certification	lac us			(7 (MANYL	1	ctuje signed (Mon	. 2003
(89		20. Name and address of	completed source of the	ath (Itam 22a) /Time			, 0		, 2003
•	D .		JAMES R - MOEN	40	100		AY LAVI	ALE , N	MARYLAND	21502
	A Sta	te	31. Date filed (Month, Day, Year)	32. Registrar 2005	's Signature,	(// #			<u> </u>	
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State of Maryland / Department of Health and Mental Hygiers

						······································	Cer	tificate of	Death		Reg. No.	UO	33421
	Physic	ian	Decedent's Name (First,							2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi			aul		Kuhn				oct.	5	2005	9:35 AM
1	Exami	ner	4a. Fecility Name (If not ins	- 1			nter	,	. 1	or Location of Dea		nty of Deeth IShi NG 1	fen
	Funeral		5. Social Security Number 505-05-1561	6.		Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 F	rs. 8. Date of Bi in. 05/17/			lace (State or Foreign
	Director		Usual Residence of Deced	ent		90				03/1//	1913		177
	nyland how	١.	10a. State 10b. C			10c. City, To						10	0d. Inside City Limits
	e Ma	ç	MD Was	hing	ton	Нас	gerst	own					1 ☑ Yes 2 ☐ No
	th with th	al Director	10e. Street and Number 750 Dual High	ıway				10f. Zip Code 21740			10g. Citizen of What Country? USA		
020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show with fujury or other treumatic event, the Mcdical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Div		12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? ∎ No		/as Decedent of P Yes, specify Cub ☐ Yes 2 R No		(Specify Yes or No erto Rican, etc.)	5- 14. R B	ace - America lack, White, e	etc.
5-0	72 ho	ted	15. De	edent's E	ducation ede completed)	168	a. Decede	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of	Business/Indu	ustry
21	ithin ithin	Completed	Elementary/Secondary (0		College (1-4o	r 5+)			d)	OIKIII	D = 4.7	امممدا	
2	lled w lygier her th	S	12 17. Father's Name (First, M	ddla I aad	1		Lo	nductor	40.14-4-4-1	(F) - 1 11 1 1 1		lroad	
and	t be f ntal H ed ot	Be	1		. Kuhn					_{ame (First, Middle} nnie E. C			
<u> </u>	should nd Me mark matic	၉	19a. Informant's Name/Rei			19	b. Mailing	Address (Street		Rurel Route Numb			Code)
Š	nd 2 g lith ar 27 is r treu		Judy A. Share		•					gerstown		21740	
re,	of Heal		20a. Method of Disposition			20b. Place				Data	OOs Lesstina	- City or Tow	vn, State
Baltimore, Maryland 21215-0020	it. Pege rtment c rtant: If njury or	20a. Method of Disposition 1							etery Mercersburg, F				
Ba	Depa Import eny Ir	l J	21. Signature of Fundral Se	Vice Licer	Eries					Funeral , Mercer	Home In	ıc. PÅ 17	7236
			23a. Part1. Enter the disea shock, or heart failure	e, or com List only	plications that caus one ceuse on each	ed the deeth. Do line.	not enter	the mode of dyir	ng, such es cardi	ac or respiratory e	rrest,		Approximate Intervel Between Onset and Death
5	Physician												Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		в	ARDI	AC	AR	RES	T			7 MINUTE
		- a	, and a second			Due to (or es e	conseque	ence of):				1	
/	d d	E L		•	b	Contractor of		14.22.25					
<u>ر</u> س	exect In end riel-tre	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Dua to (or as a	conseque	onos oij.				1	
68760,	ertificete be executed ing physician end e es the buriel-trensit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C	Due to (or as a	conseque	ence of):					
ŏ	n certif	ਣ		C	d								
ų.	death e ette ad for	sicla	Part II. Other significent co	ditions o	ontributing to death	but not resulting i	n the und	erlvina ceuse aiv	en in Part I.	23b. Did 1	obecco use c	ontribute to t	the cause of death?
л. О	es that the death ce igned by the ettend be deteched for us	by Physician	Pan					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					ably 4 ☐ Unknown
or Vital Records,	requir	Completed by								24a. Was perfo	en eutopsy rmed?	availa	e autopsy findings lable prior to pletion of cause eath?
		5								101	es 2016	101	Yes 2□No
<u> </u>	Attending Physicien: The law sr deeth. ector: After this certificete hes by the funeral director, page 2 s	Be	25. Was case referred to me examiner?	-	Hh-t					eath (Check only o	ne)		
5	Physic this o	၉	1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpat		-		Nursing	Home 5 ☐ Resid			
<u></u>	Ilng F	Ö	27. Manner of Death Natural 5 P		28a. Date of Inj (Month, Da	ay Year) 28b.	Time of njury	28c. Injun Work	/ et k? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
DIVISION	ial or Attending Ph s efter deeth. st Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ C	estigation		ijury - At home, fa	ırm street		163 2 110	28f. Location (S	itreet and Num	her or Rural F	Route Number
3	effer Dire	e I	4 ☐ Homicide	termined	building, e	tc. (Specify)	, 000	i, labibly, billoc		City or Tow		50, 0, 1,5,4,7	iosio rismbor,
	To the Hospital or A within 24 hours effer To the Funerel Dire completely filled in b	edical C	29a. Certifier 1 ☐ Cer (Check only one) 2 ☐ Med	ifying Phy ical Exam	ysicien: To the best iner: On the basis of and manner s	of examination en	, death o	ccurred et the tim stigation, in my op	ne, date and place pinion, death occ	e, end due to the c urred at the time, c	ause(s) and m late and place,	anner as stete and due to th	ed. ne cause(s)
	o the	¥ e	29b. Signature and title of ce	tifier	And mariner s	iaiou.		29c. License	number		29d. Date signe	ed (Month. De	ay, Year)
	⊢≯⊢ó) (1	N	2			DAT	1-727		10/5	105	
,	1		30. Name and eddress of per	son who d	completed cause of	death (Item 23e)	(Type, Pri	int) D	10 154	SAL MD	10/	- /	
	1		368 m:11	5	t. Hus	ecstonic		WD KIN	7 (740	.7 sal, mD			
	Sta	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature										
	Registra	ar	OCT 1	4 200	5 Holens	JA	9354						

	State of Maryland / Depa	rtment of Health and Mo tificate of Death	ental Hygiene	05 33428		
	Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	ath 3. Time of Death		
Physician	Richard Louis Lutz	S	Month Day September 28,	Year 2005 4:30 p M		
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		unty of Death		
	Suburban Hospital	Bethesda	Mor	ntgomery		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)		
Director	577-05-7036 1WM 2LIF 90 Yrs.		March 1, 1915	Washington, DC		
rland ow	10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits		
Many Many lifed lifed	Maryland Montgomery Bethesda			1 □Yes 2 No		
or 286 anoth	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?		
th will	10320 Westlake Drive, Apt. 203	20817-6443	U.S.A	1.		
J36 us after death with the Mar it; or items 23a or 28a-1 si xaniher must be notified by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. WArmed Forces? 15. Was Decedent Ever in U.S. 16. Marital Status 15. Marital Status 16. Marital Status 16. Marital Status 17. Marital Status 17. Marital Status 17. Marital Status 18. Marita	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	Race - American Indian, Black, White, etc.		
36 safte	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	☐ Yes 2፟፟Mo <i>Specity:</i>	Spe	ecify: White		
-00-		ent's Usual Occupation	16b. Kind o	f Business/Industry		
21215-00 ed within 72 hor ygiene nerthan "nature nerthan "t, tre Medical E.	(Specify only highest grade completed) (Give kilder Differentiary/Secondary (0-12) College (1-4or 5+)	ind of work done during most of workin O NOT use retired)	g	,		
d with giene ar than a mooth	4 Mechan	nical/Consulting E	ingineer Self	Employed		
be file be file doth	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Sun	name)		
Laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Amended other than "natural; or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director		Rose Lev				
Mar 12 sh 1a m raum		Address (Street and Number or Rural				
em 2:	20a Method of Disposition 20b. Place of Dispos	Westlake Drive, A	t. 203. Bet	hesda, MD 20817 on - City or Town, State		
ages ant of tr: If it	1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State '4 ☐ Donation / 5 ☐ Other (Specify) / Metropolita:	n Crematory 9/29/		ndria, Virginia		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. Important: If tien 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	1	Name and Address of Facility Gasc				
Per Per Der Der Der Der Der Der Der Der Der D		739 Baltimore Ave.		e, MD 20781		
	23a/ Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one couse on each line.	r the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between		
Physician -	Immediate Cause (Final disease or condition			Onset and Death 2 days		
/Medical Examiner	resultin (in death) Due to (or as con equence of):					
	Sequentially list conditions, if any leading to immediate b. Due to (or a a consequence of):	119		2 days		
nsit	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events					
88760, cate be executed physician and s the buriat-transit	resulting in death) Last Due to (or as a consequence of):					
68760, ficate be ext physician as the burial edical Ex	d					
68 chillipa	IF FEMALE:					
GCOrds, P.O. Box 6 law requires that the death certific as been signed by the attending p 2 should be detached for use as pieted by Physician/Mer	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Live	Ectopic pregnancy	1	Date of delivery Month Day Year		
P.O. E nat the dead to by the all etached for	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)		World Day Foat		
ds, P.(ds, P.ds, P.ds, P.ds)	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use c	ontribute to the cause of death?		
S se region			1 □ Yes 2 No	3 Probably 4 Unknown		
H Record II Record The law requir The law requir page 2 should Completed				b. Were autopsy findings available		
or e - 8 E			autopsy performed 1 Yes 2 No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
WTZ Vital Rec aician: The taw certificate has t irector, page 2 s	25. Was case referred to medical	26. Place of Death		12.10		
of Vital of Vital Physician: 1 runis certificat ral director, p	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	The second secon	e 5 Residence 6 0	Other (Specify)		
ing P	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury	Work?	3d. Describe how injury occ	curred		
If () in position or Attending the fune in by the fune in by the fune in the f	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street	M 1 Yes 2 No	Rf Location (Street and Nu	mber or Rural Route Number,		
HARD L Division of Bivision of safter death at Director: Alfart ed in by the funera Certification:	4 Homicide determined building, etc. (Specify)	st, lactory, office	City or Town, State)	mod of riotal riotal riotal,		
	29a. Certifier 15 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	nd due to the cause(s) and	manner as stated.		
RICE Hosp thin 24 hou on the Fune mingletely fill	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegenee and manner stated.	estigation, in my opinion, death occurred	d at the time, date and place	e, and due to the cause(s)		
To the within To the company	29b. Signature and the of certifier	29c. License number		ned (Month, Day, Year)		
	Wal mo	D 56652	Septa	Nock -114 MD		
nR 161	30. Name and ad vess of person who completed cause of death (Item 23a) (Type, P	rint)	C. I. A.	1 1 11		
State	31 Date filed (Month, Day, Year) 32 Registrar's Signature		enter Univi	NOCKUTTY MO		
Registrar	OCT 0 3 2005 Reste & front	راد ا				

			For State Registrar	State of M	arylan		artment rtificate			Mental Hy	giene Reg. N2 0	05	33429	
	Physici	an	Decedent's Name (First, Midd YOUNG	(le, Last) JIN LEE						2. Date of De	Day	Year	3. Time of Death	
	/Medio		4a. Facility Name (If not institution				4b. City, T	own, or Lo	cation of Deat		4c. County	05 of Death	8,30 am	
4	Examir	er e	Franklin Squar		ente	C	1	edak			Bal		e	
	- Funeral Director		5. Social Security Number 217 98 9698	6. Sex 7. Ag 1 1 1 2 □ F		last birthday) 2 Yrs.	If Under 1 Months		Under 24 Hrs Hours Min.	8. Date of Bir APRIL 2	th 25,41933	9. Birthp Coun	lace (State or Foreign S.KOREA	
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State	MORE	DATATIONE								0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
1215-0036 within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f ehow the Maryland at the motified at	h with the 23a or 28, st be not	Funeral Director	10e. Street and Number 803 CORKTREE	ROAD 10f. Zip Code 21220							S. KO	What Cour REA	itry?	
	by	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	If Yes Give			Was Decede If Yes, specif		anic Origin? (S Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		ce - Americ ck, White,	etc.		
Maryland 21215-0036 at 2 should be filed within 72 hours aft fills and Marell Hygiens, or 27 is marked other than "naturel; or traumatic event, the Marical Example traumatic event, the Marical Example 100 for the marked other than "naturel; or traumatic event, the Marical Example 100 for the marked other than 100 for the marical Example 100 for the marical Example 100 for the marked Example 100 for the marical Example 100 for the marical Example 100 for the marked		Completed	15. Decede (Specify only higher 1 ^{Elementary/Secondary (0-12)}	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR					rking	16b. Kind of Business/Industry PRIVATE				
Jand 21	be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle SUNG UP LEE	, Last)		1				ne (First, Middle OOL PAR		ne)		
Voung	1 and 2 should Health and Men Item 27 is marks other traumatic		19a. Informant's Name/Relation	ship (Type, Print) SON						MORE MD	er, City or Town, 21220	State, Zip	Code)	
ee, Vc	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (3 □Removal from State Specify)		Place of Disponental ROPOLI			ORY 1	Date 0/1/05	ALEX.,	-	wn, State	
Lec Ralli	permit. Departn Importa any injk		21. Signature uneral Service	Licensee	-					HARLES H R MARLBO			SERVICE	
68760		edicai Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Lung Due to (or as	a conseq	uence of):) bstru			such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Division of Vital Records. P.O. Box 68	it the death certifiby the attending tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic pre Other (spe					te of delive	ry Day Year	
rds P	quires that on signed b	b	Part II. Other significant condit	^		_	nderlying ca	use given i	n Part I.		obacco use cont Yes 2 □ No	tribute to th	e cause of death? ably 4 Dunknown	
Reco	The law requisate has been page 2 should	Completed	HOTERAL SENDICITIONS					autor	a. Was an autopsy autopsy findings available prior to completion of cause of death? Yes 2 10 No 1 Yes 2 No					
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medic examiner?	Hospital:					6. Place of Dea	ath /Check only	one			
on of	nding Physith. th. : After this of funeral dir	tion: To	1 Yes 2 No 27. Many r of Death 1 Natural 5 Pend 2 Accident inves	28a. Date of Inju		28b. Time of Injury		c. Injury at Work?		lome 5 Residence 1	dence 6 Oth)	
Divisi	i pit i	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	the Hospital hin 24 hours a the Funeral hpletely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated.								the cause(s)			
	Withi To t	Σ	29b. Signature and title of certification	er				License n			29d. Date signe		Day, Year)	
	0 0		~ Quance	SECUMD	loath /lu-	22a) (T:-		-	0000		9/29/05			
U	2 (3)	10	30. Name and address of person Dr. Alexander 31. Date filed (Month, Day, Year	Batcheves	9000	Fran.	Klin Sq	quare	Drive	Baltin	ure, Ma	12/	237	
	Regist		OCT 0 3	2005 Klaren	· Mr.	Soci	les							

			For State	State of Maryla		partment of H		l Mental Hy		711115	33430	
	* 3		Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)						2. Date of Death 3, Tim			
	Physici		Ervin Lockhart					Month OCTOR				
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							. County of Death	102	
			THE MEMORIA	L HOSPI	TAL	EA	STON			TAL	BOT	
	Funeral Director		5. Social Security Number 6. Sex 225-24-0751	7. Age (In yrs	s. last birthda Yrs.	Months Days	If Under 24 H Hours Mi	n. (Month, Da	av. Year	9. Births Coul	place (State or Foreign htry)	
-	pc ,		Usual Residence of Decedent	110.0	N							
	be filed within 72 hours after death with the Maryland Ital Hygiene. od other than "natural", or Iteme 23a or 28a-1 show event, the Medical Exeminar minst be multiled at	by Funeral Director	10a. State 10b. County	106. 0	ity, Town or						10d. Inside City Limits 1X Yes 2 □ No	
			Maryland Caroline 10e. Street and Number		Ridge	10f. Zip Code			10- 0			
			102 W 4th Street							itizen of What Cour JSA	ntry r	
				2. Was Decedent Ever in	U.S. 13	. Was Decedent of H If Yes, specify Cuba		(Specify Yes or No		14. Race - Americ	can Indian,	
36			1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943	į	If Yes, specify Cuba 1 ☐ Yes 2 No	in, Mexican, Pue Specify:	erto Rican, etc.)		Black, White, Specify: Whi		
, 0	2 hou		15. Decedent's Educ	ation	16a. Dec	edent's Usual Occup	ation		16b. K	(ind of Business/In		
215-0036	hin 7; Bin "n Medi	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Giv	re kind of work done of DO NOT use retired	during most of w f)	rorking			·	
7 7	od wit	Completed	12		cle	gyman			Ch	urch of	God	
land	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maider	Sumame)		
y a	should be and Mental la marked o	ဥ	Elmer Lockhart				Roxie A					
Maryland			19a. Informant's Name/Relationship (Typ			ling Address (Street a			,		Code)	
~ —	Health Health tem 27	1 3	Margaret L. Lockhan 20a. Method of Disposition			Box 861 Ri	agely,	Maryland Date		ocation - City or To	own State	
J Š	Pages nent of I ont: if it		1 A Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cr	ematory or other plac						
3altimore,			21. Signature of Funeral Service License		1 :	Shore Vet	ss of Facility	-		lock, Ma	-	
Ba	permit. Depertr Importe any inju	0.3	Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639									
25	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock or heart failure. List only on	cations that caused the dea						u 21039	Approximate Interval Between	
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition as Interval Between Onset and Death Death Deat									
			resulting in death) Due to (or as a consequence of):									
Ę			Sequentially list conditions, b.	Que to (or as a conse								
		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					_		
8760,	cate be ex physicien a the burial	dicai E								- 1		
9	tificati g phy as the	edic										
Вох	eath certific attending p	N/us	230. Was decedent pregnant	c. If yes, outcome of pregr 1 Live birth 2 Fet		□Ectopic pregnancy				23d. Date of delive	ry	
	ed for	by Physician/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)				Month	Day Year	
P.O	that the de led by the a detached	Phy	9 Unknown					00- 0:44				
Ś	Se 75 6	by	Part II. Other significant conditions cont	ributing to death but not re	suiting in the	underlying cause give	en in Parti.	239. Did ti	e cause of death?			
29a	w require been si should b	Completed									, 0	
# 29a. Records,	has ge 2 s	mp						24a. Was autop perfo		24b. Were autopsy findings available prior to completion of cause of death?		
17%			25. Was case referred to medical			770		1 ☐ Yes	25/40	1 Tes	2	
$\dot{\beta}$		To Be	examiner?	ospital. Impatient 2	ER/Outpatie	ent 3 DOA Othe	260	Home 5 Resid		6 □Other (Specify		
are li	g Physical this seral di	n; T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time			28d. Describe h)	
Sign	Attending r death. sctor: After	atio	1 Vatural 5 Pending 2 Accident investigation	(World, Day Year)	(Month, Day Year) Injury Work? M 1 Yes 2 No							
Car Division	r Atte er de recto by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, s	treet, factory, office		28f. Location (S City or Ton	Street an	d Number or Rura	Route Number,	
۵	Ital or Irs afte ral Dir led in I				Silver States							
1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. L									and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)			
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d Dat	e signed (Month, L	Day, Year)	
	⊬ s⊢ ŏ			0.10		2 2005	57110		4			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
			Dr. Dennis DeShields, 219 S Washington Street Easton, MD 21601									
	Sta		31. Date filed (Month, Day, Year)	20 Manistrada Sina	-1							
	Registr	ar	OCT 7 2005	32 Hegistrar's Sign	J. 19	23464						

State of Maryland / Department of Health and Mental Hygiene 0 05 33431 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William F. Lathom 11:10 a^M September 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 902 Dreams Landing Way Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F Months Days Hours 74 Yrs Director 229-24-7811 April 18,1931 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Dreams Landing Way 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZONo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate 4 Appraiser other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mental marked o pe William Lathom Laura Snyder ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 902 Dreams Landing Way, Annapolis, MD 21401 Vicki Lathom (Wife) item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages permit. Pages
Department of the Important: If ite any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9-28-2005 Baltimore, MD ` 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Libensee Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Kidgely Avenue, Annapolis, MD 21401 Part 1. Enter the disease, o shock, or heart failure. Lis Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final **Physician** SUB ANDUHNOID HEMMINHAGE DAX disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYELODYSPLASTIC SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit WALDENSTROMS MACROCLUBULINEMIA that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? jo Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | the detached 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy The 25 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 08/18 26 2005 VI ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLET P. ANNOTULIS RD 900 6ATTE 55 21401 15 E 31. Date filed (Month, Day, Year) egistrar's Signature State SEP 2 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 33432 For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 10:00 P M 09/25/2005 Joseph Greggor Lahocki /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Knollwood Manor Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 10/16/1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** X M 2□F 579-88-8039 63 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event. Its Madical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 899 Cecil Avenue 21108 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Employed permit. Pages 1 and 2 should ba filed I Department of Health and Mantal Hygie Important: If Item 27 Is marked other I any injury or other traumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Lahocki Evelyne Rebecca Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4816 Quimby Avenue Beltsville, MD 20705 Thomas L. Lahocki/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 09/28/2005 Suitland, MD Cedar Hill Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Juneral Statice Linesee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, of comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Z HOURS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dicease or it jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit and Due to (or as a consequence of): the attending physician a hed for usa as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISORDER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes After this certificate 2 ⊠No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely fillad in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 031136 mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALLACE MD 50
Year) 32. Registrar's Signature 9005 KILBRIDE RD., BALTIMORE, MD 2/236 31. Date filed (Month, Day, Year) State 2 8 2005 Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>			giene 0 0	5 33433
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
-	Physici /Medi		Helen		LoVeco	hio		Septem	ber 22,	2005 9:40 a M
	Examir		4a. Facility Name (If not institution, give	street and number))	4b. City, Town	, or Location of E	eath	4c. County	of Death
			3525 Elizabeth Co	urt		Chesa	peake Be	each	Calv	<i>r</i> ert
	Funeral		5. Social Security Number 6. Sec	7. Ag	ge (In yrs. last birthday,	If Under 1 Year Months Day		Hrs. 8. Date of Birt Min. (Month, Da	h v, Year)	Birthplace (State or Foreign Country)
н	Director		351-01-1730	JM 20 F	87 Yrs.			Oct 1,		Missouri
	and *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	/anyl	ō	MD (G-]			Ch a mar	analaa Da	la		1X Yes 2 No
	28a-	rect	MD Calvert 10e. Street and Number			10f. Zip Code	oeake Be		10a. Citizen of W	Vhat Country?
	with Ba or	Funeral Director	3525 Elizabeth Co	urt			732		USA	
	ins 2	era		12. Was Decedent	Ever in U.S. 13.			? (Specify Yes or No- uerto Rican, etc.)		· American Indian,
9	or Ite	Fur	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No i			uerto Rican, etc.)		k, White, etc.
5-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dissa Examinat must be rodified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1⊡Yes 2XIN	o Specify:		Specify	white
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occ	upation e during most of	working	16b. Kind of Bu	siness/Industry
2121	ithin be.	Jdr.	Elementary/Secondary (0-12)	College (1-4or	5+)	kind of work don DO NOT use reti				
2	led w tygier her tl		12 17. Father's Name (First, Middle, Last)		heal	th care		Non- (Final Minds)		ntial health
anc	be fi	Be		LoVecch	ni			Name (First, Middle,	_	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Evantiner must be notified at once.	2	Felix 19a. Informant's Name/Relationship (Ty.			on Address (Stra	Auror	a r Rural Route Numbe		ecora
Ma	d 2 s th an t7 ls		Steve LoVecchio,	•						n, MD 20732
ā,	Heal Heal tem 3		20a. Method of Disposition	riepriew	20b. Place of Dispe	sition (Name of		Date		City or Town, State
<u>o</u>	ages ant of t: If i		1 X Burial 2 ☐ Cremation 3 X☐R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	matory`or other p		01 2005	uillaid	lo TT
altimore,	artme ortan injur		21. Signature of Funeral Service License	99		2. Name and Add	_	-01-2005	Hillsic	ie, IL
B	Depar Depar Impor any ir once.		William R	Crow.	> F	ausch Fi	meral H	one, P.A.	. Owtnes	, MD 20736
	THE REAL PROPERTY.		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cation that caused	d the death. Do not en	1/77				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		imer's Deme	ntia				Onset and Death 21 months
	/Medical		resulting in death)		a consequence of):	пста				Z1 ROIGIS
н	Examiner		Sequentially list conditions							
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8760,	cate be executed bhysician and the burial-transit	<u>E</u>	is a sum of the sum of	Due to (or as	a consequence of):					
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Вох	atten for u	clan	in the past 12 months?		2 Fetal death 3	Ectopic pregnan Other (specify)	су		Mon	,
P.O.	the d y the iched	Physiclan/M	1 ☐ Yes 2X No 9 ☐ Unknown	9☐ Unknown		,,,				
	The law requires that the death certifi tie has been signed by the attending age 2 should be detached for use ac	by Pi	Part II. Other significant conditions con	tributing to death b	out not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
rds	quires n sign uld be	d be	Seizure Disorde	<u> </u>				1 🗆 Y	es 2∭No	3 ☐ Probably 4 ☐Unknown
Records,	aw requir s been si s should l	plet	Severe Arthriti	5				24a. Was a		/ere autopsy findings available
Re	sicien: The law s certificate has t irector, page 2 s	Completed						— autop: perfor 1 ☐ Yes	med? de	rior to completion of cause of eath? Yes 2 No
Vital		Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only or		
of V	> 07 70	일	1 ☐ Yes 2 X No	ospital: 1 🗌 Inpatie	ent 2 ER/Outpatier	it 3□ DOA O	ther: 4 🗆 Nursin	g Home 5X Resid	ence 6 Othe	r (Specify)
			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	28c. Inj	ury at ork?	28d. Describe h	ow injury occurre	d
sio	Attending ir death. ector: Aftei by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
Division	I or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	•	28f. Location (S. City or Town	treet and Numbe n, State)	r or Rural Route Number,
	pital ours a eral [29a. Certifier 1X Certifying Phys	inion. To the best	of my knowledge, deat					
	Hos 24 hc Fun etely	Medical	(Check only 2 Medicel Examination)	er: On the basis of	f examination and/or in	vestigation, in my	opinion, death o	ccurred at the time, d	ate and place, ar	nd due to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of continer			29c. Licer	nse number	2	9d. Date signed	(Month, Day, Year)
	->-0		1 1/1	alson.	~ VW	D 5	51722		Septemb	er 26, 2005
			30. Name and address of sers of one	mpleted cause of d	leath (Item 23a) (Type,				•	
	10		Kimberly Larsen, I				ite 111	, Prince F	rederic	k, MD 20678
	Sta		31. Date filed (Month, Day, Year)	32. Registr	s Signature	4 74				
	Registr	ar	SEP 2.3	2005	Coone . K	Crest?	y			

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State of Maryland / Department of Health and Mental Hygie $^{2}005$ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2110 PM Bobby Gene Mills 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 54415644 Wicomico REGIONAL medical Peninsula CONTU If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7-17-1935 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ₩ M 2 🗆 F Days Hours Min 70 234-52-6952 Director Kentucky Usual Residence of Decedent the Maryland 10c. City Town or Location 10b County 10d. Inside City Limits 10a State ahow 77 is marked other than "natural", or ttama 23a or 28a-f abov traumatic avent, it o Modical Experiment be nutilled at Delaware Sussex Frankford 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Rd#4 Box 18 19945 US death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 54-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Self Employed Master Plumber College (1-4or 5+) Elementary/Secondary (0-12) Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Menta! H tant: If item 27 is marked ot! Luther Mills Romaine Little 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita C. Gronas/ Sister 1042 South Wildwood, Westland, MI. 48186 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Dispositie 1 ☑ Burial 2 ☑ Cremation 5 moval from State permit. Page Department of Important: If any injury or once. Mills, Horn, & Crumm 10-8-2005 Turkey Creek, Kentucky 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Melson Funeral Services, Ltd. 21. Signatur y f Funeral Sery Thatcher St., Frankford, DE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic melen om a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 2 Fetal death 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Division of Vital is after deam.
I'mel Diractor: After this cerum.
I'm by the funeral director, p or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO059368 10/2/05 of person who completed cause of death (Item 23a) (Type, Print) DH. 12+1 John Visioli Salisbury MD 100 B. Carroll St. 21501 31. Date filed (Month, Day, Year) 0CT 0 3 32. Pristrar's Signature State Registrar

For	State of	of Maryland /	Depa	artmen	t of H	ealth a	and
1 = For Stata Registrar			Cer	tificat	e of L	Death	
1. Decedent's Name (First, Midd	fle, Last)			-			
Christine I	ouise Mars	sh					
4a. Facility Name (If not institution				4b. City,	Town, or	Location	of Dea
Washington	County Hos	spital		F	lager	stow	n
5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)			If Under	24 H
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	1 = For State Registrar		State o	ı maryı		artment of F <i>rtificate of</i>			ientai Hy	/giene Reg. No	Z U	05	33435	j
an	Decedent's Name (F	First, Middle, Las	st)		-				2. Date of D		y	Year	3. Time of Death	
al er	4a. Facility Name (If no	ne Ioui ot institution, give yton Cou	street and nu	mber)		4b. City, Town, o	r Location		Octobe	40	. County	2005 of Death	1237 A	VI.
	5. Social Security Num 579–48–456 Usual Residence of De	6. S		-	vrs. last birthday,	If Under 1 Year Months Days			8. Date of B (Month, D	irth ay, Year		9. Birthpl Count	ace (State or Foreign) achusetts	
tor		Ob. County Washi	ngton	10c.	City, Town or L	estown						10	0d. Inside City Limit	
al Direc	10e. Street and Number 12010 Smi		Farm L	ane		10f. Zip Code 2174	10					What Count		
Be Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 [12. Was Dec Armed Fo 1 Yes If Yes, Gr Year or D	orces? 2 ∑ No ve	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ②X No	lispanic Or an, Mexica Specify:		ecify Yes or N Rican, etc.)		14. Rad Bla	ce - America ck, White, e	in Indian, itc.	
ompleted	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress 18. Mother's Name (I							ng			usiness/Ind	•		
To Be C	17. Father's Name (Fin Henry						G	race	Loui	e, Maidei .se	spi	nney	Lewis	
	19a. Informant's Name James Ed			(husb	- 1	ng Address <i>(Street</i>)10 Smith:								
	20a. Method of Dispos 1 ☐ Burial 2 X C 4 ☐ Donation 5 [Cremation 3		State	cemetery, cre	osition (Name of matory or other place org Cremat	· .	10-5	5-05			City or Tov	_{vn, State} Iaryland	
	21. Signature of Funer	cla A	: Xu	i W	1	2. Name and Addre	ern B	lvd.	N. Hac	erst			al Home and 2174	2
(23a. Part1. Enter the shock, or heart to tmmediate Cause (Fin disease or condition resulting in death)		a	Respir	eath. Do not en	far the mode of dyin	g, such as	cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death	
lner	Sequentially list condi- if any, leading to imme cause. Enter Underly Cause (Disease or inju-	tions, ediate ing	b P	neun	nomice of):	1	Daca					Ĉ	neweek	_
clan/Medical Examiner	that initiated events resulting in death) Las		c. Due to	(or as a con	sequence of):	Ш	Dise	usc					1915	
Iclan/Me	IF FEMALE: 23b. Was decedent pr in the past 12 mo	onths?		tcome of pre birth 2 DF nant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)	,					te of deliver	y Day Year	

Physician /Medical Examiner

ettending physicien and for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician /Medica Examine

Funeral Director

> Be Completed by Physician/Medical Examiner Medical Certification;

9 Unknown 9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

2 No

2 No 1 Yes

25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) patient 1 ☐ Yes 25 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 1 Atatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

29d. Date signed (Month, Day, Year)

30. Name and address opperson who completed cause of death (Item 23a) (Type, Print) 203116 31. Date filed (Month Cay, Year) 6CT 0 6 2005

State Registrar

3

within 24 hours after death.

To the Funeral Director: A completely filled in by the ft

State of Maryland / Department of Health and Mental Hygier 0 0 5 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28, **Physician** Year 2005 Margaret Haas Murphey September 8:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Rockville Montgomery Hospice-Casey House Montgomery If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. Min. (Month, Day, Year)

May 7, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. 183-18-6407 87 Ohio Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Silver Spring Maryland Montgomery 1 Yes 2 XNo Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20902 415 Hillsboro Drive USA 238 death v Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Itams 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "natural", or iten eny injury or other treumatic event, the Medical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman Haas Cecelia Holtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. Murphey/ Daughter 325 Lowerline Street, New Orleans, LA70118 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 3, 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Debility disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Lymphoid Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Advanced Dementia Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 \ No 1 TYes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 2 1 ☐ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) Hospice this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1X Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier \leq 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Charles Harrison, MD 31. Date filed (Month, Day, Year) 32#Registrar's Signature State 2005 Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of	lealth and Death		2005	33437
	Physici	an	1. Decedent's Name (First, Middle, La	st)			-	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Andrew Harvey	Muir		1 0 T			r 27, 200	
	Examin	er	4a. Facility Name (If not institution, given Shady Grove Adv.)			Rockvi	TLocation of Deat	in	4c. County of Dea Montgome	
	Funeral	~~	Social Security Number 6. 8	Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs			hplace (State or Foreign buntry)
	Director		212-68-1919	1 2 M 2□F	69 ^{Yrs.}	Months Days	Hours Min.		1935 Sco	tland
9000	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d Inside City Limits
	Mary -1 she	tor	Maryland Montg	omery	Rockvil	le				1 □Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath wi	ral C	261 Congression			20852			USA	
36	be filed within 72 hours atter death with the Maryland stal Hygliene. Ind other then "natural", or Heme 23a or 28e-f show event, I'ra Madical Evertiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
2-003	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business	
2121	ithin 7 18.	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or :	life.	kind of work done DO NOT use retired	during most of wo d)	rking		
2	Hygier Hygier other th		12 17. Father's Name (First, Middle, Last		Fo	reman	4D Mark and No.	(F 14:40- 14-	Construc	tion
and	ould be f Mental F arked of atic ever	o Be	Robert Muir	,			Mary Un	me (First, Middle, Ma	iden Sumame)	
Maryland	2 should be and Mental Is marked (To	19a. Informant's Name/Relationship	Туре, Print)	19b. Maili	ng Address (Street		ural Route Number, C	ity or Town, State, a	Zip Code)
	and 2 salth a n 27 ls		Callista A. Sal	tibus/ Gua	rdian 1290	9 Saddleb	rook Dri	ve, Silver	Spring,	MD 20906
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury peother traumatic enones.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other (Speci			osition (Name of matory or other place an Cremator	- 1000	. 1,	c. Location - City or	Town, State Virginia
Balt	permit. Departitimport. eny inj		21. Signature of Funeral Service Lice	I Cole	F 5	2. Name and Addre rancis J. 00 Univer	ss of Facility.	Funeral H	Home Inc	g, MD 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	plications that caused one cause on each li	the death. Do not en ne.	ter the mode of dyir	g, such as cardia	c or respiratory arrest		Approximate Interval Between
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P.O. Box (Attending Physicien: The law requires that the death certific releath. sctor: After this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
o. O.	igned by be deta	by Ph	Part II. Other significant conditions		ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been si should t		128	US				1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	nysicien: The law his certificate has b director, page 2 st	Completed						24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of
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<u></u>	Attending Par death.	atlo	Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury		k? Yes 2 □ No		,	
Divis	el or Atte s after de el Directo	Certification	3 Suicide 6 Could not be determined	28e. Place of inj	ury - At home, farm, st c. (Specify)	reet, lactory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number.
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best miner: On the basis o and manner sta	ol my knowledge, deat f examination and/or in ated.	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	a, and due to the caus arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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			30. Name and address of person who Truong Bao, M.D.	13219 Ex	ecutive Par		e, German	ntown, MD	20874	
A STATE	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 3 20	05 Registr	ar's Signature	de				

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death

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								4b. City,	Town, or	Location	of Death		4c. (County of Death	
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Fune	ral		5. Social Security N	lumber 6.	Sex 7. A	e (In yrs. I	**					8. Date of Bir	th v. YearL	9. Birth	place (State or Foreign
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ermit epert	g		21. Signature of Fu	neral Service Lic	ensee		22	2. Name an	d Addres	ss of Facili	ty Har	ry H.W	itzke	e's Fami	ly F.H.Inc
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ner		Name (If not institution		oer)	4b.	City, Town, o	r Location of Dea	ath	40	c. County of	Death	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - State of Maryland / State of Maryland /	Department of Health and Me Certificate of Death	ntal Hygiene 005	33440
Physician /Medical	1. Decedent's Name (First, Middle, Last) Oliver Watson Mundis	2.	Date of Death Month Day Year 10 07 2005	3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number) EAGLE View Elder Care	4b. City, Town, or Location of Death Whiteford	4c. County of Death	irel
Funeral Director	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs. If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.		hplace (State or Foreign untry) RYLAND
yland how	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or Location		10d. Inside City Limits
or 28e-f s	MD HAR FOR A 10e. Street and Number Bel A	10f. Zip Code	10g. Citizen of What Co	1 □ Yes 2€ No wntry?
Tey, INICAL YIGHTO ZELETONOSO S 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Item 27 is marked than "naturel; or litems 23e or 28e-f show other treumstic event, it a Madical Enginer resist be indiffed at To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	21014 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric		e, etc.
2 hours at aturel, or cell Exert	3 Widowed 4 □ Divorced If Yes, Give Year or Dates WIII 15. Decedent's Education 16a	1 ☐ Yes 2 ☑ No Specify: Decedent's Usual Occupation	Specify: Whi	
ed within 72 holygiene. ygiene "neturn neturn" t, the Medical E	(Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) Chemist	Civil Servi	ice
yidilio A.1.A. rould be filed within Mental Hygiene. narked other than natic event, It a M. To Be Comp	17. Father's Name (First, Middle, Last) John Mundis		First, Middle, Maiden Sumame) Thompson	
e, ivial yid t and 2 should Health and Men Health ard Men em 27 is marke ther treumatic		b. Mailing Address (Street and Number or Rural F 4 Canning House Lane,		Tip Code) 1918
Dalkilliore, bermit. Pages 1 ar Department of Hea Importent: If item any injury or othe	1 € Burial 2 □ Cremation 3 □ Removal from State Cemete	of Disposition (Name of pay, crematory or other place) Ridge Cemetery 10/12/20		
partition permit. Pages 1 Department of P Importent: If ite eny injury or of gnce.	21. Sgnature of Funeral Service Licensee	22. Name and Address of Facility Harkins Funeral Home, Inc.,	500 Main St.,Delta, I	PA 17314
Physician	a. /an1. Chter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition a		espiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner	Due to (or as a consequence say. Enter Underlying Cause (Disease or injury)	artery disease		years
icate be executed physician and s the burial-transit edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence d	of):		
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cords, P.O. wrequires that the been signed by the should be detache	A1212	in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
has b			autopsy prior to o death?	topsy findings available completion of cause of
VITA VITA Ilcien: certific rector,	25. Was case referred to medical examiner?	26. Place of Death (C		Acriched Civin
on or or ding Physics. After this funeral di	1 Inpatient 2 ENO		d. Describe how injury occurred	racility
DIVISION C el or Attending P elter death. Il Director: Attent d in by the funera	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	Location (Street and Number or Ru City or Town, State)	ral Route Number,
DIVISION OF To the Hospitel or Attending Phys within 24 hours effer death. To the Funerel Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge of the basis of examination and manner stated.			
To th withir To th comp	29b. Signature and title of certifier	29c. License number D53186	29d. Date signed (Month October 8	
169	30. Name and address of person who completed cause of death (Item 23a)		Uctober	7,20
10	Julie Tinney MD 615 W	MiPhail Rd Bell	Air mo alory	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

			For State Registrar	State of M	laryland	d / Depa <i>Cer</i>	artment of F tificate of a	lealth and N Death		gien e Reg. No.	005	33441	
	Dhaminia		1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath Day	Year	3. Time of Death	_
	Physicia /Medic		Carol Martell						Septemb			3.4	
	Examin	er	4a. Facility Name (If not institution, gi)		4b. City, Town, or	Location of Death		4c.	County of Dea	ath	
			15935 Germant 5. Social Security Number 6.		ge (In yrs. la	et hirthday)	Germant If Under 1 Year		8. Date of Birt	_	ntgome	ery inhplace (State or Foreign	_
	Funeral Director			1 M 2 M F	81	Yrs.	Months Days	Hours Min.	Sept 2	y, Year)	924 Nev	w Hampshire	
			Usual Residence of Decedent						F				_
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	Ba-f s	Director	Maryland Montgome	ery	Gern	nantow							_
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	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner must be notified at	Funerai	15935 Germantown	12. Was Decedent	t Ever in U.S	S. 13. V	Vas Decedent of H	ispanic Origin? (Sc	pecify Yes or No-		14. Race - Am	nerican Indian	
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2	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itams 23a or 28a-1 show other than "natural", or Itams 23a or 28a-1 show event, the Medical Examiner must be notified at	മാ	17. Father's Name (First, Middle, Las	t)		Dustii	C35 OWIICI	18. Mother's Nam	ne (First, Middle,		Sumame)		_
	Mental Merkad o	To B	Earl Forsaith					Marion L	egge				
ary	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	٦.	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	an <i>d Number</i> or Ru	ral Route Numbe	r, City or	Town, State,	Zip Code)	Н
Ξ	and 2 salth a n 27 I		K. Melisa Martell	/daughter			Germanto	wn Road	Germanto				
ore	of He of He of item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	Ce	metery, cren	sition (Name of natory or other place	-/	tember		cation - City o		
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a a	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Lice	insee Otto		Ğ	Name and Address HOME	S Cremati	on Serv	ice	P.O. I	3ox 784	
			23a. Part1. Enter the disease, or cor	nplications that cause	MO12 ed the death						arksvil	1e, MD 2102 Approximate	9
			shock, or heart failure. List only tmmediate Cause (Final	one cause on each l	line.		•	3,	,			Interval Between Onset and Death	
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cora	w requir been si should	ted	- hte Men	Cancer					1 🗆 Y	es 2	3 □ F	Probably 4 Unknown	
Φ	has b	Completed							24a. Was autop	sv	24b. Were a	utopsy findings available completion of cause of	
E E	: The law cate has								perfor 1 ☐ Yes	2010	1 Ye	s 2□No	
Vita	Phyaician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea					-
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0	Attending or death. ector: After by the fune	atio	1 Pending 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury		k? Yes 2 □No					
DIVISION	of or Attend after death Director:	ertification;	3 Suicide 6 Could not determined	286. Place of In	njury - At hor	me, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and	Number or A	Rural Route Number,	-
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	To the Hospital of within 24 hours af To the Funeral Completely filled in	ledical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the besi miner: On the basis of and manner s	of examinati	vledge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time, or	ause(s) a date and	and manner a place, and du	e to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	11	_		29c. Licenso	e number	4	29d. Date	signed (Mon	th, Day, Year)	
			16/4	Alle	m		1)	27/41		S	Minle	-29,2005	-
)0	22		30. Name and address of person who	completed cause of	death (Item	23a) (Typ).	Print)	al.	21701	LI	and H	-29,2005	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0	2005 32. Poist	trar's Signati	ure	land.		1.47	7-10	44-117		
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05-06814 Andrew M. Mannix

		1 = State Unpend Item	State of Mary 23a,27,28a	yland / Dep f per me	artment of Hea G848 10-18 rtificate of De	alth and M 3-05 tas eath	lental Hygi	iene 00	5 33442
14 1 1 1 1 1 1		1. Decedent's Name (First, Middle, La					2. Date of Death	h	3. Time of Death
Physici /Medio			Martin Mar	nnix			Octobe:		2005 09:11 A ^M
Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or Loc	cation of Death		4c. County o	f Death
	St.	Shady Grove Adver		al n yrs. last birthday	Rockvi	11e Under 24 Hrs.	O Data of Birth		ontgomery
Funeral Director		217-11-0352	M 2□F	19 Yrs.		Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
		Usual Residence of Decedent	1	19			April 2	1986	Maryland
nylan how		10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
e Ma	cto	Maryland Montgon	ery	Gaithers	burg				1 ☐ Yes 2 ☐ No
or 20	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?
and 21215-0036 be filed within 72 hours after death with the Maryland nia! Hygiene. bd other than "natural", or Items 23a or 28s-1 show event, its Madical Examinar must be notified at	rai	25214 Bonny Bro		11.0	20882			U.S.A	
iten de	Funeral	11. Marital Status 1 → Never Married 2 → Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 Who	r in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	Mexican, Puerto	Rican, etc.)		- American Indian, White, etc.
Urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣No S	Specify:		Specify:	White
2 ho	ted	15. Decedent's E (Specify only highest gi			dent's Usual Occupation kind of work done during			16b. Kind of Bus	
217	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ng most of work	,,9		
d 21 filed w Hygier other th	S	12th		Stu	dent			High Sc	
yland buid be fi Mental H arked otl	Be	17. Father's Name (First, Middle, Las			18.		(First, Middle, N	faiden Sumame,)
Marylan 2 should be 2 should be and Mental 7 is marked of	P	Martin Joseph Ma 19a. Informant's Name/Relationship		19h Mail	ing Address (Street and		Fields	City of Tourn S	tate, Zip Code) 20882
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. Z? is marked other than "natural", or traumatic event, its Medical Exami		Martin J. Mannix			4 Bonny Bro				
		20a. Method of Disposition		20b. Place of Disp	osition (Name of	and the second			ity or Town, State
Pages ant of tr. if i		1 ⊠ Burial 2 ☐ Cremation 3 [4 ☐ Domation 5 ☐ Other (Spec		-	Cemetery	10/14	/05 R	ngerewil	lle, Tennessee
Battimore, Dermit. Pages 1 at Depertment of Hea mportant: if Item any injury or oths		21. Signature of Fureral Service Lice			2. Name and Address of lin L. Mole				
Deperiment of the property of		forest L.	Villiam	2	lin L. Mole 6401 Ridge	Road.	P.A., Fu Damascus	neral H . Marvl	ome and 20872
S8760, // Medical Examiner be executed by physician and burial-transit superprise and superprise	Examiner	23a. Pant1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	intoxicat onsequence of:					Interval Between Onset and Death
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cords, F w requires tha been signed I should be det	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the o	underlying cause given in	n Part I.			ute to the cause of death? ☐ Probably 4 DUnknown
	e Completed							pri led? de l No 10	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
2 16 =	To Be	25. Was case referred to medical examiner? TY□ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 X ER/Outpatie	Other		(Check only one ne 5 ☐ Residei		(Casada)
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DIVISIO PHOSPITE OF Attendi 24 hours after death. Funarel Director: A	Certification:	3 ☐ Sutcide 6 【ACould not I 4 ☐ Homicide determined	De Diago of Injunt	- At home, farm, st	reet, factory, office	A	28f. Location (Str City or Town, nd Rt.27	eet and Number State) Ridg , Damas	or Rural Route Number e Landing Kd. cus, Md
Division To the Hospitel or Attending within 24 hours after death. To the Funarel Director: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of ex- and manner stated	amination and/or in	nvestigation, in my opinio	on, death occurre	and due to the ca ed at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	. 11 . 1		29c. License nu OCME	ımber			Month, Day, Year)
•		Yanuk 90	Whall, MD						07, 2005
		tamela E.S.	completed cause of death)		n Stree	t Balti	more, Ma	aryland 21201
Sta Registr		31. Date filed (Month, Day, Year) OCT 1 4 2	32 Aegistrar's	Signature	nede				

For AMEND#23a PER PHY State of Maryland / Department of Health and Mental Hygiene State 9/27/05 AACO HEALTH DEPT. CMH Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 24, 2005 **Physician** Jobie Dexter Morris 2:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 12 M 2 □ F 69 Yrs. 213-32-6187 Director 12, 1936 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County en "netural", or items 23e or 28e-f show Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Boxwood Road 21403 U.S.A. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XXYes 2 □ No If Yes, Give Year or Dates: 1959–65 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: Specify: β White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Party Chief (Supervisor) Surveying 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any njury or other treumatic event, 900s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Davis Morris, Sr. Jeanetta Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 Roselawn Road Annapolis, Maryland 21403 Linda Armstrong/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State INBurial 2 ☐ Cremation 3 ☐ Removal from State akemont Mem. Cardens 9/29/2005 Davidsonville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Rome 0 147 Duke of Gloucester St., Armapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypotension /Medical Due to (or as a consequence of): 6 hours gostwardstmal bleer Examiner-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown Completed Stoge Hidrey Disease on Hundridgis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated. 29b. Signature and title of certifier NO8314 110 Défende Lighuay Annopalis, MA 2140/ who completed cause of death (Item 23a) (Type, Print) nw Zasami 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 20533444 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 12:34 PM JUNE WARING MAYNARD October 4, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 F Months Days Hours Yrs. Director 214-22-3779 79 2, 1926 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes XXNo Directo Maryland Frederick Myersville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Items 23a.or permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27-18 marked other than "natural" once. 9062 Dawn Court 21773 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sameul Stevens Thelma Rawlings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Maynard / husband 9062 Dawn Ct. Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematoriom 10/6/05 4 Donatien Other (Specify Smithsburg, Maryland 21. Signature of Fugleral Service Licentee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Exter the disea shock, if he it failure. L mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seps į 2 week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit physician and Due to (or as a consequence of). P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? certificate 2 No After this certific funeral director, 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical mpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059283 October 05, 2005 Hospitalist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Street Frederick MD 470 39 Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2005 Registrar

		•	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of F tificate of	lealth and I Death		giene Reg. No.	005	33445
	Physici	_	1. Decedent's Name (First, Middle, Last)	1 NIFLD				2. Date of De Month SEPTEM	Day	Year ZOO5	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give st	reet and number)			or Location of Death	2		ounty of Death	
	- Funeral Director		1 1 1	M 2□F 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Bir			place (State or Foreign Intry) Land
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
	h the Mar	Funeral Director	Maryland Washingto 10e. Street and Number	n Hage	rstown	10f. Zip Code			10g. Citize	n of What Cou	1 ☐ Yes 2 ☐ No untry?
	s 23a o	erai D	1047 View St. Apt		2 12 4	21742	Jianania Origina /S	Panifu Vac or No	USA	. Race - Amer	iogo Indian
326	urs after de al', or item examinar	by Fune	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes ZZZNo If Yes, Give Year or Dates:		Yes, specify Cub	Hispanic Origin? (S lan, Mexican, Puerl Specify:	to Rican, etc.)		Black, White	, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar round be notified at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give I life. [OO NOT use retire	during most of wo	rking	16b. Kind	of Business/li	ndustry
	Hygien Hygien ther th		17. Father's Name (First, Middle, Last)	2	Contr	actor	18. Mother's Nar	me (First, Middle	L	Constr	uction
ylan	Mental Mental arked c	To Be	James D. Nield		,		Evelyn				
Maryland	id 2 sho Ith and 27 is ma trauma		19a. Informant's Name/Relationship (Type Barbara Nield/Wife		1	g Address <i>(Street</i> View St.	t and Number or Ru	ural Route Numb Hagersto			
Baltimore,	Pages 1 an ent of Heal nt: if Item 2 y or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. P	lace of Dispos emetery, cren	sition (Name of patory or other pla	ice)	Date -2005	20c. Loca	tion - City or T	Town, State
Baltii	permit. P Departmi Importar any injure		21. Signature of Funeral Service License Shall Sign				ess of Facility Resylvania				-
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death cause on each line.	Do not ente	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
) **	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		T.A. 1	21/250/15	_			
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38760,	licate be executed physicien and s the burial-transit	al Examin	Cause (Disease or injury that initiated events resulting in death) Last	DIABETE Due to (or as a consequ		ELLIT	15				
•	entificate ding physes as the	Medical	IF FEMALE:	3c. If yes, outcome of pregna	nov						
P.O. Box	st the death certiflic by the ettending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnand Other (specify) _	cy	25-110-5-1	23	d. Date of deli- Month	very Day Year
	quires thet n signed b uld be deta	Ď	Part II. Other significant conditions con	tributing to death but not rest	ulting in the u	nderlying cause g	ven in Part I.	1	tobacco use		the cause of death?
Vital Records,	The law requires thet the sete has been signed by the page 2 should be detache	Completed			_			24a. Was auto peri 1 Yes		24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			hor	ath (Check only			
ō	ding Phys	tion: To	1 ☐ Yes 25 No 27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Nursing i	dome 5 Res 28d. Describe			erfy)
Division	of or Attending effer death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office)		(Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospitel of within 24 hours of To the Funerel D completely filled in	Medical C		ner: On the best of my knowner: On the basis of examina and manner stated.							
	To the To the compl	Me	29b. Signature and title of certifier			ļ	se number			signed (Monti	
•		1	30. Name and ad ress of person who co	empleted cause of death (Iten	n 23a) (Tvne		15113		SEPTE	MBER	- 21, 2005
5	4-1		GRISHMIN JUSHI 1	10 22 S. GI	LEENE		MUTIMOR	E, MD	21	201	
180	St Regist	ate	31. Date filed (Month, Day, Year) OCT 0 1 200	32 Registrar's Signa	ture And	Les de de		•			

For State Registra

. Decedent's Name (First, Middle, Last)

Box 68760. O ۵ Records, Division of Vital or Attending Physicien: After death. after deat Director: To the Hospital o within 24 hours aff To the Funerel Di completely filled in 30 4

Vice President Defense Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental H Anthony Francis Nardello Rose DeMeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st nent of Health and ant: If item 27 len Jeannette E. Nardello/ Wife 2404 Braddock Rd. Mt. Airy, MD 21771-8800 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematorium 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury of once. * 4 □ Donation 5 □ Other (Specify Alexandria, Virginia 30, 2005 21. Signature of Funeral Service L 22. Name and Address of Facility 10 East Deer Park Drive, Gaithersburg, MD 20877 disease, or complications that caused the death. ailure. List only one cause on each line. 23a. Part1. Ener in dis shock, of heart faill Immediate Cause (Final disease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death GASTRO - INTESTINAL hours /Medical Due to (or as a consequence of) T HROMBUCYTOPENIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X/Vo 3 Probably 4 Unknown 24a. Was an autopsy performed? Ves 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 2 1 Tes 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D004436 -61. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Enrico Giangeruso, M.D. 200 Memorial Avenue, Westminster, Maryland 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar **ORIGINAL**

Month Day
September 28, **Physician** 2005 John Pasquale Nardello 11:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 057-54-7557 76 Yrs 1929 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Івтя 23e 2404 Braddock Road 21771-8800 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No Korea If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) September 29, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 0 0 5

2. Date of Death

33446

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Neal 12:35 p M September 29, Lloyd 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18100 Chalet Drive, #102 Germantown Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2 □ F Months Days 215-28-1587 73 16, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18100 Chalet Drive, #102 29874 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ceval Aaron Neal Beulah M. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18100 Chalet Drive, #102, Germantown, MD 20874 Mary Patricia Neal/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 30 Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc amos 500 University Blvd, W, Silver Spring, MD 20901 Part1. Inter the disease, or complications that cause 1.19 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Pancreas Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Arthritis, Bladder Cancer 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27301 September 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas Shumaker, M.D.

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physicien: after death Director: within 24 hours To the Funerel Tol

Physician

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Director

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Director

Completed by Funeral

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Certification: To

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

Registrar

30 2005

31. Date filed (Month, Day, Year)



615 W. Montgomery Avenue, Rockville, MD 20850

Physicia /Medica Examine Funeral Director		1. Decedent's Name (First, Midd	de, Last)				tificate				Reg. No.			
Examine uneral	- 1	Elma W. Nes	ter							2. Date of De Month SEPTEM	Day	27,2	ear 2005	3. Time of Death
		4a. Facility Name (If not institution				35	4b. City, Tor					County of		Leho
		5. Social Security Number 173–01–6633	6. Sex 1 ☐ M	-		. last birthday)	If Under 1 Y		der 24 Hrs.	8. Date of Birt (Month, Da Sept. 2	h v. Year)	9	. Birthpl	ace (State or Foreign
ehow d.m.	_	Usual Residence of Decedent 10a. State 10b. Count	•	1	10c. Ci	ity, Town or Lo	_						10	od. fnside City Limits
or 28a-f	Director	10e. Street and Number	Arunde			Severna	10f. Zip Co		-		10g. Citi	zen of Wh		1 ☐ Yes 2 🛣 No
of, or Items 23s	by Funeral	52 Sunset Dr. 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. W A rried 1 If	med For Yes Yes, Giv ear or Da	2 X No	1	Yes, specify ☐ Yes 2 ☑	No Spe	Origin? (Sprican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Black, Specify:	White, e	itc. te
7 is marked other then "nat freumatic event, the Madica	Completed	(Specify only high Elementary/Secondary (0-12)	- i		-4or 5+)	16a. Deced (Give life. L	ent's Usual O kind of work o OO NOT use r Homema	one during i etired)	nost of work	king	16b. Ki	nd of Busir HO		ustry
atic event	To Be	17. Father's Name (First, Middle John R. Wood	o, Last)					18. M	other's Nam	e (First, Middle, Emma Ke				
Department of Health and Menta Important; if item 27 is marked eny injury or other treumatic events.		19a. Informant's Name/Relation Thomas A. Nes 20a. Method of Disposition 1 □ Burial 2 □ Cremation	ter/Hus	sband	20b.	52 S Place of Dispos cemetery, crem	Sunset sition (Name of hatory or other	Drive	Se	everna F Date Oct. 1	Park,	MD cation - Ci	211 ty or Tov	46 vn, State
Department Important; eny injury once.	Ī	4 Donation 5 Other (21. Signature of Funeral Service	Specify)	2,	va.	Ba Ba	Name and A Arranco 5 Gov.	ddress of Fa	acility ns. P	2005 . .A. Sev	erna	ley F	k Fu	neral Hom D 21146
rsician ledical aminer	Examiner	23a Fart Nenter the disease, a shock or heart failure. List immediate/Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that infliated eyents	a	Due to (aused the deal ach fine. 13 ROV or as a consecutor as a cons	quence of):	er the mode of	ACC /	as cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
physicie	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	yes, out	come of pregninth 2 Feta ant at time of cown	ancy	Ectopic pregr Other (specif				2	23d. Date o Month		y Day Year
bed .	þ	Part II. Other significant condit	tions contribut	ing to de	eath but not res	sulting in the un	derlying caus	e given in P	art I.			se contribu		a cause of death? bly 4 Minknown
has 3e 2	Completed											prio	r to com	sy findings available pletion of cause of
director.	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospit	1421] ER/Outpatient	3□ DOA	04		h Check only o	ne)			
Director: After th	Certification:	3 Suicide 6 □ Could	tigation	e. Place	h, Day Year)	28b. Time of Injury	М	Injury at Work? 1 Tyes 2	!□No	28f. Location (S City or Tow	Street and	d Number	or Ru ra l	Route Number,
	Medical Co	29a. Certifier Certify 2 Medice ope). 29b. Signature and title of certify	a a	711 WIN DE	best of my knows; of examination of examination of examination of examination of the exam	owledge, death ation and/or inv	estigation, in	ne time, date my opinion, cense numb	death occur	and due to the cred at the time, c	date and	and manni place, and	due to	the cause(s)
		30. Name and address of person Zeluke Dess	leass n who complete E 1150	ted caus			Print)		7 3	s Sprin				27,200

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State of Maryland / Department of Health and Mental Hygiene 2005 33449 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Norfolk **Physician** Louise Month Day Sept. 21, 2005 12:45P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Frederick Calvert Memorial Hospital Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthpface (State of Months, Day, Year) | Mar, 16, 1910 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** 1 M 2 XF 95 Yrs. Director 579-32-8351 Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or iteme 23a or 28a-f eho tre Modical Examiner must be notified at 1 ☐ Yes 2 No ⊵Maryland Calvert Huntingtown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3165 Evans Road 20639 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 le marked other then r traumatic event, the Ma Elementary/Secondary (0-12) Coflege (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Norfolk Joseph Christiana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Health ar Importent; if item 27 le eny injury or other trau Prince Fred, MD Sandra Tyler/Granddaughter 310 Rivers Reach Ct. #219 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Plum Pt. UMC Cem. 19/27/05 Huntingtown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit monan Die to (or as a consequence of): Box 68760, Physician/Medical t)e 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitaf: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation frigury 1 Tyes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060475 INN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 HOSPITAL RD, PRINCE PREDERICK MD 20678 BUSH IMD TEREZ 1A 31. Date filed (Month, Day, Year) 32. Registra Signature State 2005 Green & Registrar

			1- State Registra AMEND#SperFH10/3/05, EW, McCo	epartmentofd290tyaedh Certificate of Death	ental Hygier	2005 33450
	Physici		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	/Medic		Dorothea E. Oliver			er 17, 2005 6:18 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Charles County Nursing & Rehab Cente	4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles
_	Francis	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8 Date of Birth 1	914 9. Birthplace (State or Foreign
ы	Funeral Director		577-01-1042 1 M 2 F 91 Y	Months Days Hours Min	8. Date of Birth 19 1/27 1/27	Massachusetts
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town			
	laryla shov	5				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-1	rect	Maryland Charles Waldon 10e. Street and Number	10f, Zip Code	100.0	Citizen of What Country?
	3a or	Funeral Director	14050 Poplar Hill Road	20601		USA
	ema 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No	1 ☐ Yes 2 ☒ No Specify:	Tricari, etc.,	Black, White, etc. Specify: White
21215-0036	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show Jical Examitter must be motified at	q pa		ecedent's Usual Occupation	104	
215	in 72	Completed	(Specify only highest grade completed)	Give kind of work done during most of work ife. DO NOT use retired)	ring 160.	. Kind of Business/Industry
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yla	Men Men Marke Marke Marke	1º			th Diggins	
Maryland	d2sh thanc 7 Isn traun			Mailing Address (Street and Number or Run		
ē,	Heal Heal		20a. Method of Disposition 20b. Place of D	050 Poplar Hill Rd;		D 20601 Location - City or Town, State
e E	and in Sur	ľ	1 X Durial 2 Cremation 3 Hemoval from State	crematory or other place) on National Cem 10/	5/2005 A1	clington, VA
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If time 27 is marked othar than "natural; or Itema 23a or 28a-1 show any injury prime 21 is marked othar than "natural; or Itema 23a or 28a-1 show any injury prime 21 is marked ownt, the Marical Examiner must be notified all once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	nes-Rinald	li Funeral Home
2	82589		Mylint. Wlobert			Lver Spring MD 20904
. 16		2	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	nysician	ğ V	Immediate Cause (Final disease or condition resulting in death) a. Bladder Cancer			Onset and Death
	/Medical Examiner		Due to (or as a consequence of	:	11	
911	H_U	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse of injury)	: \	1/1/	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause Disasse or injury that initiated events c	CERTIFICATION APPROVED BY M	EDICAL EXAMINER	
o,	e exe	Exi	resulting in death) Last Due to (or as a consequence of	CERTIFICATION APPROV		
8760,	cate be executed physician and the burial-transit	dicai	d	V		
	leath certifi attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			and Date of data
Вох	death certiff e attending id for use as	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
O.	of the c by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
s, P	The law requires that the de ite has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in to	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
p Z	w require been si should b		Hip Fracture		1 🗆 Yes	2 No 3 Probably 4 ⊠Unknown
Record	e faw r has be je 2 sh	Completed	Anemia		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
					performed? 1 ☐ Yes 2 ☑ N	death?
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Other	(Check only one)	
	문 + E	1-	27. Manner of Death 28a. Date of Injury 28b. Tin	tie of 28c. Injury at	me 5 Residence 28d. Describe how in	6 ☐Other (Specify) jury occurred
io	Attanding ir death, actor: After by the funer	atio	TSNatural 5 Pending (Month, Day Year) Inju 2 Accident investigation 09/06/2005 5:20	wark? Ca.m. 1 ☐ Yes 2 X No	Subject f	fell
Division	I or Attandated after death Diractor:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify) Nursing and Reha	, street, factory, office	28f. Location (Street a	and Number or Rural Route Number,
Ω	oital o urs af aral D			5.	0200 LaPla	Nursing & Rehab Ctr
	⊄o the Hospital or Attan within 24 hours after deat To tha Funaral Diractor: √ompletely filled in by the	edicai	29a. Certifier 15c Certifying Physicien: To the best of my knowledge, ((Check only one) 25d Medicel Examiner: On the basis of examination and/one) and manner stated.	leath occurred at the time, date and place, a or investigation, in my opinion, death occurr	and due to the cause(ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	othe othe	Med	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
) \	X 3		Y blusse + narawi	D55455 /D005	CRK? Son	A 29. 2005
1	29		30. Name and addess of person who completed cause of death (Item 23a) (Ty	,0 ,	- 55	~ / -
1425			Fatima Y. Hussein, M.D., 5625 Aller	town Road, Ste. 101	, Camp Spr	ings, MD 20746
R	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	gods!		

State of Maryland / Department of Health and Mental Hygien 33451 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 09-28-2005 **Physician** Sr. Everette Nathaniel Proctor a^M 2:47 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ho1y Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1.2-11-1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**™**M 2□F Hours 579-58-7735 60 Director Washington DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show may injury or other traumatic event, the Medical Examinat must be notified at once. PG MD Adelphi 1 TX Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10312 Floral Dr. 20783 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 28 No Specify: Specify: Black 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Procurment Contractor City Of Rockville 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Everett Pau1 Proctor Geneva Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shawn Hicks Son 0312 Floral Dr., Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Pk 10-04-2005 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Buneral Service Licensee H 1722 N. Capitol St. NW Washington DC 20002 ona 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Ventricular Fibrillation /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit c. Hypoventilation that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Obesity 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertension has e 2 certificete 2 🗆 No 1 🙀 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation neral Director: A filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9.30,200 4 10 100

Registrar DHMH 17 Rev 1/2001

State

Ave,

Kensington,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Epstein

03

31. Date filed (Month, Day, Year)

10810 Conn.

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) September 26 2005 11:15 M **Physician** John Pindell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7 Lee St. Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 21 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral 1**X** M 2□ F Months Days Hours 88 Yrs. 212-14-3960 1917 Director Maryland Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumstic event, the Medical Exact at marker notified at Maryland Annapolis 1 □XYes 2 □ No Anne Arundel Director the 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 7 Lee St. 21401 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: 1945-46 2 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Flementary/Secondary (0-12) College (1-4or 5+) Laborer Naval Academy 9th 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John W. Pindell Ruth Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other treum John Pindell(Son) 102 Dogwood Rd. Annapolis, Md. 21403 20b. Place of Disposition (Name of Marginetaly Application Notes Place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-29-05 Crownsville, Md. Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) Moouse Wm. Reese & Sons Mortuary, E 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee Jane Rese 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEWISNIA Pnysician 2425 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last burial-transit and The law requires that the death certificate be exect Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 2 No 1 Yes 1 ☐ Yes spitel or Attending Physician: Thours after death.
Inerel Director: After this certificate this obtained in by the funeral director, ps 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 130718 09-27-2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) under MA 71401 Town State Registrar

State of Maryland / Department of Health and Mental Hygienes 33453 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Elizabeth Emerson Poore 2005 Sept 24 1800 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) NOV 23 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🙀 F 57 Yrs 215 58 3404 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ul Hygiene. other than "natural", or Iteme 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Calvert Huntingtown Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 130 Cox Road 20639 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) auto repair shop Automobile 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Elizabeth Lewis Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be and Mental ! Charles Edward Emerson, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tret once. John Ronald Poore- husband 130 Cox Rd. Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 28 2005

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee DKausc 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypoxemia **Physician**) ever u /Medical Due to (or as a consequence of): Examiner senmenger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Hypertension
Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o 9□ Unknown 9 Hinknown ģ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? insufficience 2 No 3 Probably 4 Unknown accider 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? mellitus Dinsetes 1 Yes 2 10 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA this Diractor: After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 060390 2005 MD 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL RO. PRINCE FREDERIUR MO JABER 100 DEEB 31. Date liled (Month, Day, Year) 32. Registras Signature State 2 9 2005 Registrar

William Hen	ry Pitsnogle
05-06799 -	
RPD	1 - For State Registrar
	 Hegistrar

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State of Maryland / Department of Health and Mental Certificate of Death	Hygiene,	20	E***
Certificate of Death	Bed No	JU	J

019	79 -		For State Registrar		State of	Marylan		ertificate of		_	iene	005	33454
	Physici		Decedent's Name (F	irst, Middle, Las	•	am Hen	ry Pit	snogle		2. Date of Dea Month October	th Day	2005	3. Time of Death
9	/Medic Examir		4a. Facility Name (If no	t institution, giv					r Location of Death		1	County of Death	
			Washington	County	Hospita	al		Hagerst	own		Wa	shingto	on
	Funeral Director		5. Social Security Numb 218-30-8904	1	ex € M 2 □ F	7. Age (In yrs. 77	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 19	, Year)	9. Birth Con 28 Ma	nplace (State or Foreign untry) Lry1and
	9		Usual Residence of De-			1.0			<u> </u>				
:	Marylar 8-f ehow	ctor		ob.County Vashing	on	10c. Cit	y, Town or l		stown				10d. Inside City Limits 1 X Yes 2 ☐ No
	28 th	Director	10e. Street and Numbe	ır				10f. Zip Code		1	0g. Citiz	en of What Co	untry?
	23a c	aiD	523 Church	Street				2	21740			U.S.A.	
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funerai	11. Marital Status 1 Never Married		12. Was Dece Armed For 1 Yes If Yes, Give	2 XNo	.S. 13	. Was Decedent of I If Yes, specify Cub		pecify Yes or No- p Rican, etc.)]	4. Race - Amer Black, White Specify:	e, etc.
ğ	ural',	d b	3 ☐ Widowed 4 ☐		Year or Da	ites:						WI	ite
Maryland 21215-0036	vithin 72 P ne. hen "nat	Completed	(Specify of Elementary/Secondary	Decedent's Econly highest gra	lucation de completed) College (1	-4or 5+)	(Giv	edent's Usual Occuj e kind of work done DO NOT use retire	during most of word d)	king	16b. Kin	d of Business/l	ŕ
2	lied v tygie her t		12 17. Father's Name (Firs	et Middle I ast				Manag		ne (First, Middle,	Maiden 9	Plar.	IT.
מב	od of	Be				-7-0				tha S. T.			
<u> </u>	d Me d Me nark natic	은	19a. Informant's Name		Pitsnog	1e	10h Mai	ling Address (Street	L				in Codal
<u>8</u>	d 2 s th an 7 le r traur		Mary E. Pi		**	. 1		Church St					
e,	1 and Heelt am 2 ther		20a. Method of Disposi		= (MTIE					Data T		ation - City or	
Baltimore,	Pages ment of ant: If it ury or o		1 Burial 2 XC 4 Donation 5	remation 3		ciate		position (Name of ematory or other pla nrg Cremat	l l	2005		=1	Maryland
<u>z</u>	permit. Depert Import eny in		21. Signature of Funera	al Service Licer	isee			22. Name and Addre	•			Funera	
	<u> </u>		- Clare	Jæ.	DAVIS	MOI	414	2525 Brac	lbury Ave	. Smiths	burg	, Maryl	and 21783
F	Physician		23a. Part1. Enter the o shock, or heart fa Immediate Cause (Fin- disease or condition	tilure. List only	one cause on ea	ach line.					est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as a conseq	uence of):	st wow	10 07 11-	eng.			
V	led nsit	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events	tions, ediate ng iry	b. Dua to (or as a conseq	uanca of):						
8760,	cate be executed physician and i the burial-transit	ai Exar	that initiated events resulting in death) Last		Due to (or as a conseq	uence of):						
87	phys the	dicai			_ d								
P.O. Box 6	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent prein the past 12 mointh of the past	nths?		inth 2∐Feta antattime ofd	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23	3d. Date of deli Month	very Day Year
S, D	ires that t signed by d be detar	by Ph	Part II. Dther significan	nt conditions	ontributing to de	ath but not res	ulting in the	underlying cause gr	ven in Part I.				the cause of death?
ב	w require been sig should b	ed								1 🗆 Yı	es 2	No 3∏Pro	bably 4 Unknown
Vital Records,	sicien: The law re certilicete hes bee irector, page 2 sho	Completed								24a. Was a autops perform	SV	death?	topsy findings available ompletion of cause of 2 \square No
/Ite	icien: certifice ector, j	Be	25. Was case referred examiner?	to medical	Unnite!			1 -		th (Check only or	ie)		
	- U E	11 - 1	177 Vac 2 No		Hospital:			i O!!	ner:				

To the Hospital or Attending Physic within 24 hours after death.
To the Funeral Director: After this ca completely filled in by the funeral directors. Division of

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Subject shot self 1 ☐ Yes 2 No 0-5-05 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

October 6, 2005

and address of person who completed cause of death (Item 23a) (Type, Print)

ACON CA TO AKNO 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
OCT 1 4 2005

State Registrar

Medical Certification;

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State of Maryland / Department of Health and Mental Hygiene

				State of Ma	aryland	l / Depa <i>Cer</i> i	rtment of tificate of	Health and Death	Mental Hy	giene (05 3	3455
			Decedent's Neme (First, Middle, Las	")					2. Dete of De	eth		Time of Death
	Physicia		Donna Louise H	Rilla					Septem	ber 29.	2005 1	0:50 a.m.
	/Medica Examine	al -	4e Fecility Name (If not institution, give					4b. City, Town, or				
	Examine		Holy Cross Nursing	and Reha	abilit	ation	Center	Burtonsv	ille	Montgo	merv	
_	Funeral		Social Security Number 6. Security Number	x 7. Ag	e (In yrs. le	st birthday)	If Under 1 Year Months Day	r If Under 24 Hrs	8. Date of Bi			(State or Foreign
	Director		292-44-2093	□M 21X0F	60	Yrs.	WOTHIS Day	I TIOUTS	July 2	9, 1945	Ohio	
9	D	-	Usuel Residence of Decedent		100 City	Town or Loc	eation				10d I	nside City Limits
	anyla Show		10a. Stete 10b. County				ation					I□Yes 2¶∑No
	Ne M	- G	Maryland Prince Ge	eorge's	Lanh	nam	10f. Zip Code			10g. Citizen of V		
	with t	<u></u>	10e. Street end Number	1						U.S.A.	viiat Country :	
	aath	era	7103 Forbes Boulev	12. Was Decedent	Ever in U.S	13 W	20706	Hispenic Origin? (Specify Yes or N		e - American II	ndien.
	Hem hem	Š	1 Never Married 2 Married	Armed Forces?		If	Yes, specify Cu	ban, Mexican, Pue	rto Rican, etc.)		k, White, etc.	
22	irs af	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Yeer or Detes:		1	☐ Yes 2M N	Specify:		Specify	African	-American
ğ	be filed within 72 hours after death with the Manyland tal Hygjena. I other than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, its Medical Examiner must be rigitied at	8	15. Decedent's Ed	ucetion		16e. Deced	ent's Usuel Occ	upetion	at to a	16b. Kind of Bu	siness/Industr	у
215	nin 7	Pie	(Specify only highest gred Elementery/Secondary (0-12)	le completed) College (1-4or 5	5+)	life. E	ana of work don O NOT use retii	e during most of wo ed)	orking	DC Gener		
7	d wit	Completed	12			Speec	h Patho	logist		Children	n's Cer	iter
g	othe	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumam	10)	
<u>la</u>	uld b Wants rked rice	2	Stanley Crawford					Loretta	Velar			
lan	s me	d	19a. Informant's Name/Relationship (T	ype, Print)		19b. Meilin	g Address (Stre	et end Number or F	Rurel Route Numb	er, City or Town,	Stete, Zip Coo	fe)
Σ	and salth		Bernice Witkowski	- Friend		mode in		enue, New				
Baltimore, Maryland 21215-0020	permit. Pagas 1 and 2 should be filed within 72 hours aftar daath with the Marylan Department of Health and Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	20b. Pla	ice of Dispos metery, crem	sition (Name of atory or other p	lace)	Date	20c. Location -	City or Town,	State
Ĕ	Pag mant: I		4 □ Donation 5 □ Other (Specify		Meti	copoli	tan Cre	matory 10	/02/2005	Alexand	ria, Vi	irginia
alt	Departs mports mports any inj ance.		21. Signature of Funeral Service Licens	600			Name and Add	ress of Fecility Funeral H	Iomo D /			
m	80 E 8 9	1	Mark Jak	1/				timore Av			le, MD	20781
		\neg	23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only of	lications that caused	the death.	Do not ente	r the mode of d	ying, such as cardia	ac or respiratory	errest,	Apı	proximate erval Between
1	Physician		,								On	set and Death
-	/Medical		Immediate Cause (Final disease or condition	a adva	nced	MAR	fastut	is color	canc	er	4	years
	Examiner		resulting in death)	a		es e conseq					1	
	R 5	dicai Examiner		b								
	tha death cartificata be assocuted y tha attanding physician and sched for use as the burial-transit	хац	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying		Due to (or	es e consequ	uence of):					
8760,	be a) ician buris	置	Ceuse (Disease or injury	c								
387	phys tha	윷	that initiated events resulting in death) Lest		Due to (or a	as e consequ	ience of):				1	
9 X	ding sa as	ğΙ		d								
Вох	v raquiras that tha daath cartific been signed by tha attanding p should ba datached for usa as	Physician/M							oot Bid	A-10'	- A-15	anne of death?
P.O.	tha d	ıysi	Part II. Other significant conditions co	ntributing to death b	ut not resul	ting in the un	derlying ceuse (given in Part I.		_/		cause of death? ' y 4 □ Unknown
Δ.	d b	=							. '-	Yee 2 No	3 - PIODEDI	y 4 Onkilowii
Division of Vital Records,	raquiras that veen signed b	Completed by								s an autopsy		autopsy findings
δ	v raq beer shou	e e							pen	ormed?	comple	etion of cause
Re	sician: Tha law cartificata has b liractor, paga 2 s	티							10	Yes 2 No		s 21 No
ल	ficate or, pa		25. Wes case referred to medical					26 Place of De	eath (Check only			22.10
Ē	Physician: r this cartific ral diractor,	o Be	evaminer?	Hospital: 1 □ Inpatie	ant 2∏F	R/Outpatien	3 DOA	Whor:		idence 6 □Oth	er (Specify)	
ō	Phys rrthis eral d	⊢⊦	27. Menner of Deeth	28e. Date of Inju	iry :	28b. Time of	28c. In		7	how injury occurr		
ion	Attending For death. Sctor: After by the funer	탏	1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	y real)	Injury		☐Yes 2☐No				
Visi	Atter ctor by th	<u>≅</u>	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inj	jury - At hor	ne, farm, stre	et, factory, offic	в		(Street and Numb	er or Rural Ro	oute Number,
Ö	s afte	Certification:	4 Nothicide	building, et	o. (Specify)				Only or 10	, , , , , , , , , , , , , , , , , , , ,		
	To the Mospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	cai (29a. Certifier 1 Certifying Phy	reiclan: To the best Iner: On the basis o	of my know	ledge, death	occurred at the	time, date end pled	ce, end due to the	cause(s) and ma	inner es stated	d.
	he H in 24 he Fi	edicai	one)	end menner st	eted.	on one or new						
	To the Com	2	29b. Signature and title of certifier	10. S. TI	-	m . C		nse number 2034726		29d. Date signer		
			Jusmus a	er jui	i	(-/)	00	W31166	-	Septemb	27	, 2003
	(10)	İ	30. Name end address of person who o	ompleted ceuse of c	leeth (Item	23e) (Type, I	Print)	246	- · · · · A	o Hom	Rath	de un
12	(1)						D- , 8.	719 MISC	DUSIN MU	(., 302,	Demes	da, MD 20214
5-4	Stat Registra		31. Dete filed (Month, Day, Year)	2. Registr	er's Signati	Ire.	et u					

			1 - For State Registrar	State of Ma	aryland / I	Depa <i>Cei</i>	artment of F rtificate of	lealth and Mo Death		en2 005	33456
I			Decedent's Name (First, Middle, L.	ast)					2. Date of Death Month	1	3. Time of Death
	Physici /Medic		KIMBEF	LEY S.	RICHE	Y				30, 2005	
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Death		4c. County of De	ath
I			7821 Briarda 5. Social Security Number 6.		Ce e (In yrs. last bii	rthda.d	De If Under 1 Year	rwood ff Under 24 Hrs.	R Date of Birth		GOMERY
	Funeral Director		220-72=8130	1 M 20 F	41	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 1	3,1964	rthplace (State or Foreign Country) Illinois
	v		Usual Residence of Decedent						ounc 1	3,130,1	11111010
	anylan show	Ē	10a. State 10b. County		10c. City, Tow		_				10d. Inside City Limits
	18a-f	ecto		gomery		Der	wood				1 X Yes 2 No
	within 72 hours after death with the Maryland liene. r than "netural", or Itams 23e or 28e-f show It e Madical Exacultar Inval Le notified at	Funeral Director	10e. Street and Number 7821 Briarda	le Terra	ce		10f. Zip Code	0855	10	g. Citizen of What 0	•
_	ter dea Itams Iter no	-uner	11. Marital Status 1 □ Never Married 2€3€Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1		13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	erican fndian, ite, etc.
5-0036	ours af	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2€ No	Specify:		Specify: T	White
ئ ا	72	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a	. Dece	dent's Usual Occup kind of work done	oation during most of workin d)	g 1	6b. Kind of Busines	
7	filed within Hygiene. Ither than "	Idmi	Elementary/Secondary (0-12)	College (1-4or 5	i+)			manager	Γ	4ealth & Servic	
N O	filec Hyg sthe	ပိ	17. Father's Name (First, Middle, Las	4 yrs			TOGLAM	18. Mother's Name	(First, Middle, M		
Maryland	lid be lental ked c	To Be	Robert A.	Magidson				Dian	ne V.	Germaine	<u> </u>
ary	shou and M s mar	-	19a. Informant's Name/Relationship		196	. Mailir	ng Address (Street	and Number or Rural	Route Number,	City or Town, State,	Zip Code)
	and 2 salth a n 27 i		Dana Richey	(Husband)				dale Ter	., Der	wood, MI	20855
ore	of He roll		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3	□Removal from State	20b. Place o cemete	f Dispo	sition (Name of natory or other plac	Da Da	ate 2	Oc. Location - City of	r Town, State
Ē	Pag tment tent: jury c		'4 Donation 5 ☐ Other (Spec	ity) /	Metro			Srv 9-30		Alexandı	
Baltimore,	permit. Pages 1 and 2 should be Deparment of Health and Menta Importent: If item 27 is marked any injury or other treumatic evense.		2) Signatur Funeral Service Li	Have	wea			ss of Facility SNO Jash. St.			IOME, P.A. ID 20850
	, to		23a. Part1. Enter the disease, or co shock, or heart ailure. List on	mplications that caused	the death. Do	not ent	er the mode of dyin	ng, such as cardiac or	respiratory arres	st,	Approximate fnterval Between
i	Physician		Immediate Cause (Final disease or condition	col	/	01	cer				Onset and Death
,	/Medical Examiner		resulting in death)	Due to (or as	a consequence						
	LAdiminer	Name of the last	Sequentially list conditions,	b. Sup to for se	enneupeanon a	A.					
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	200 (0) 20	ei siui isoquoi kio	Oij.					
,	icate be executed physician and s the burial-transil	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):					
09/89	sicia sicia e bur	edical		d							
_	rtificate ng phys as the	led	IEEE MARKET	V7X-2-11X-1-		-				7	
X P P	eath certifi attending I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	3 🗆	Ectopic pregnancy	,		23d. Date of de Month	Day Year
0	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ☐ No 9 Z Unknown	4□Pregnant at 9□Unknown	time of death	5	Other (specify)			World	Day 75a.
7	s that ned b e deta	by Pt	Part If. Dther significent conditions	contributing to death b	ut not resulting i	n the u	nderlying cause giv	en in Part f.	23e. Did toba	cco use contribute	o the cause of death?
Hecords,	w requires been sig should b								1 ☐ Yes	2 □ No 3 □ F	robably 4 Unknown
000	law re as bee	Completed							24a. Was an autopsy		utopsy findings available completion of cause of
	The ate h page	Com							perform	ed? death?	
Vital	cien: ertific actor,	Be (25. Was case referred to medical examiner?					26. Place of Death	(Check only one,		
0	Physic this c	70	1 Yes 2 No	Hospital: 1 Inpatie		,		4 LI Nursing Hom		ce 6 ☐Other (Spe	ecify)
	ding I h. After funer	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of fnju (Month, Da)		Time of Inju ry	28c. Injur Wor M 1	yat k? Yes 2 □ No	8d. Describe how	Injury occurred	
DIVISION	Attender deat	fica	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At home, fa	ırm, str	eet, factory, office			et and Number or F	ural Route Number,
S	s after s after al Dire	Certi	4 Homicide	building, etc	c. (Specify)				City or Town,	State)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	hysicien: To the best miner: On the basis of and manner sta	examination an	e, death	occurred at the tin restigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th To th compl	Me	29b. Signature and little of certifier	dl.	^		29c. Licens	e number	290	. Date signed (Mon	th, Day, Year)
)	105)	30. Name and address of person wh	completed cause of d	1 / D	(Type	Print) 49.	27802	J.	entember	30,2005
			Wells Mess	ersmith.	U.D 4	101	North.	DROADIUM	ay, Bal	timore, N	1 21231
	Sta Registr		31. Date filed (Month, Day, Year) OCT 03	2005 32. Hegistra	ar's Signature	Ap	sell)				
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** DROTH 2005 11:50 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ruxton Health of Denton Denton Caroline If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex Funeral Deys Months 1 □ M 2 🖸 F Director 214-05-1132 Usuel Residence of Decedent Sept.13,1919 Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland Caroline Denton 10g. Citizen of Whet Country? America 10e. Street end Number 10f. Zip Code Funerai 517 Gay Street 21629 United States (No- 14. Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0. Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Caucasian þ 3€ Widowed 4 Divorced Be Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Unknown parmit. Peges 1 end 2 should be file Departmant of Heelth end Mental Hy Important: If them 27 is marked oths any injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Cannon Edith Ward 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 517 Gay Street, Denton, Maryland 21629

20b. Place of Disposition (Neme of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Son Roland L. Roy, Jr 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Capitol Crematory 9/29/05 Dover, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signalare of Funeral Service Livensee 12 South Second Street, Denton, Maryland 21629 accept Fart I Enter the discess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical CEREBRAL EDEM A

Due to (or as a consequence of): DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner eral Director: After this certificata has been signed by the attanding physician and filled in by the funeral director, page 2 should be datached for use as the buriel-transit Physician: The law requires that the death certificets be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that in the control of the contro Division of Vital Records, P.O. Box 68760 ATHLO SCLENOTIC that initieted events resulting In deeth) Lest Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? 27 Menner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier ATTENDING MD D0053094 e end eddress of person who completed cause of death (Item 23e) (Type, Print) 321 KINBOW, BLOOMING & AVE MU 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 3 SEP 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 ten / per 11 848 10-15-05 yt. State of Maryland / Department of Health and Mental Hygiene 0 5 33458 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GARLAND RICHMAN 11:40PM MUID OCT 2005 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMONE If Under 1 Year If Under 24 Hrs. 6041 KIRK N 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□ F 58 Months Days Hours Min. Yrs. 229-66-6190 Director 1946 VIRGINIA DCT 16 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6041 ALKIRK KOAN 21239)SA or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 20 Yes 2 □ No 1967-If Yes, Give Year or Dates: 1969 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No by Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ray lajury or other traumatic event, If a Med 2008. Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) ersonnel KECRUITER HOSPITAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHMAN WAKeman HALL WILLIAM Kuth H . 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dellinger 1011 Shenan noah Square, woodstock UA 22664 151STER KUTH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MASSANUTTEN Cen. Oct 10,2005 WOODSTOCK, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JN Zun Bww FH & man Co. umbrun 6028 Sykesville Rong Expensions Mo 21784 23a. Carti Errer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 017 meta 5) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 Tyes 2 [] NO 1 Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 Mesidence 6 ☐ Other (Specify) ပ 1 Tes 2 THIS 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Certification; 1 ENatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Attenda

State Registrar

DHMH 17 Rev 1/2001

5 2005

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30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

MD

Vano

2 DIVAG 31. Date filed (Month, Day, Year)



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			For State Registrar	State of M	laryland	•	rtment of I		and Mei		ne 200	5	334	59
	Physici	an	Decedent's Name (First, Middle, Las Margaret Bush	Reynolds		-, -,				Date of Death		Year	3. Time of 1637	Death
4	/Medio Examin		4a Facility Name (If not institution, give 11450 Asbury Circ				4b. City, Town, C So Lomor	or Location o			4c. County o			
*	Funeral Director		218-30-4000		ge (In yrs. Ia 87	nst birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Yearch 6 1	ear)	9. Birthp Cour Cana	* *	r Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert			, Town or Los OMONS	cation					1	0d. Inside Ci	·
	h with the	Funeral Director	10e. Street and Number 11450 Asbury Circ	ele Apt 10)6		10f. Zip Code 20688	3		10g.	Citizen of Wr		try?	
036	be filed within 72 hours after death with the Maryland that Hygiene. od other than "naturel", or Items 23e or 28e-f show event. The Medical Examinat must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 12 If Yes, Give Year or Dates:	? [No	If	Vas Decedent of H Yes, specify Cub	an, Mexican	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. Race Black Specity:	Amenic White,	etc.	
Baltimore, Maryland 21215-0036	e filed within 72 ho al Hygiene i other than "natur vent, I'n Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		5+)	(Give I life. E	ent's Usual Occup kind of work done NOT use retire Assitant	during most d)	of working		o. Kind of Bus		dustry	
land 2	uld be filed Aental Hygid rked other tic event, L	To Be C	17. Father's Name (First, Middle, Last) Ross Bush							irst, Middle, Mai e Titus	den Sumame,			
, Mary	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve		19a. Informant's Name/Relationship (7 Patricia Collyer-			12 Gra	g Address (Street 1y Lee Av	ve. To	ronto	Ontario	ry or Town, S Canac	ate, Zip la	Code)	
imore	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Metr		sition (Name of latory or other pla can Fune)				. Location - C exandri	a V		a
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licen	500			Name and Address						20676	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Hypei	rtensi	.on	r the mode of dyl	ng, such as o	cardiac or re	espiratory arrest,			Approximate Interval Bety Onset and E	ween
ì	Examiner	16	Sequentially list conditions, if any, leading to immediate	b. Due to (or as										
8760,	death certilicate be executed e attending physician and id for use as the burial-transit	al Examiner	Cause. Ernef Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
9	ertiticate ling physi e as the l	Medical	IF FEMALE:	d		×000-4		***						
.O. Box	that the death certitic ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ▼ 0 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnance Other <i>(specify)</i>	y			23d. Date Month			'ear
rds, P	sign d be	by	Part II. Dther significant conditions co	ontributing to death t	but not resul	ting in the un	derlying cause giv	ren in Part I.		23e. Did tobace			e cause of de	
Il Records,	The law ate has b page 2 st	Completed								24a. Was an autopsy performed	Orio	re autop or to con ath? Yes	osy findings a apletion of ca 2 \square No	ivailable luse of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 E	R/Outpatient	3□ DOA Oth	AF.		heck only one)	6 □Other	(Specify	}	
ion of	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely tilled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	urv 2	28b. Time of Injury	28c. Injur Wor	y at	28d.	Describe how in			/	
Division	tel or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f.	Location (Street City or Town, St	and Number ate)	o <i>r Rural</i>	Route Numb	70 <i>r</i> ,
	he Hospitel or in 24 hours atte he Funeral Dire pletely tilled in b	Medicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Example (Check only one)	ysician: To the best iner: On the basis of and manner st	of examination	rledge, death on and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, death	place, and n occurred a	due to the cause at the time, date	e(s) and mann and place, and	er as sta d due to	ated. the cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-Box	H	<u> </u>	29c Licens	052	242	29d.	Date/signed (Month, E	Day, Year)	
	15		30. Name and address of person who o				•	310 F	rince	Freder	ck MD	206	78	
	Sta Registr		31. Date filed (Month, Day, Year)		rads Signatu	ire								

	1 - For State Registrar	S	State of Ma	ryland / Dep <i>Ce</i>	artment of I <i>rtificate of</i>		Mental Hy	giene 0	05 33460)
Physiciar /Medica			nnah	Rigglem	an		2. Date of De Month	Day	Year OH:20 A	
Examiner Funeral	4a. Fecility Name (If not	Heart	HOSPIT	TAL (In yrs. last birthday,	Cum If Under 1 Year	If Under 24 Hrs	DU	9 9	y of Death 2900 J	
Director	232-26-53 Usuel Residence of Dec	31	²□ X 8	8 Yrs.	Months Days	Hours Min.	8. Date of Bir Month, Da Mar 2	". 1917	Country) MD	
a-f ehow	1441	Mineral		10c. City, Town or L Ridg					10d. Inside City Limit	
th with the Mar 23a or 28a-fel	10e. Street and Number Route 3 Bo	ox 374			10f. Zip Code	26753		10g. Citizen of	What Country?	
1775-50036 within 72 hours after deeth with the Maryland ene. then "naturel", or Iteme 23a or 28a-f ehow he Medical Exeminer dust be notified at homeleted by Finneral Director	3 ☑ Widowed 4 □	2 Married	Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No to Rican, etc.)		ce - American Indian, ck, White, etc.	
be filed within 72 hours after deeth with the Marylan tal Hygiene. Id chier then "naturel", or lieme 23a or 28a-f ehow event, the Medical Examinat must be notified at the Completed by Figures in Director	(Specify or Elementary/Secondary	Decedent's Education of the highest grade control (0-12)	ion ompleted) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire maker	pation during most of wo d)	rkıng		usiness/Industry	
	17. Father's Name (First,					_	me (First, Middle Huff Tay	, Maiden Surnar		
Mary and 2 should he and 27 le my r traum.	19a. Informant's Name/F James Rig	Relationship <i>(Type,</i> gleman	Print) SON	19b. Maili Rt.	ng Address (Street 1 Box 174	and Number or Re	Poute Numb	er, City or Town, eley	State, Zip Code) WV 26753	
D - 1 5 5	20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5	emation 3 Rem	oval from State	20b. Place of Dispo cemetery, cre. Newhouse	matory or other pla	ce)	Date 10/12/200		City or Town, State	
Baltimo permit. Pages Depertment of Important: If it any injury or o	21. Signature o Funeral	Service Licensee	Im	U 2	Name and Address Scarpe 108 Vir	ที่ที่ f ็นก็ตับ ginia Avenu		rland. MD	21502	
Physician /Medical	23a. S. Enter the dis ock, or heart faild Immediate Suse (Final disease or condition resulting in death)	ure. List only one o	PERM	DUITIS					Approximate Interval Between Onset and Death	
icate be executed physicien and s the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ate c.	PERFO Oue to (or as a	consequence of): RATED consequence of): consequence of):	VISCUS				5 DAYS	
death certif		hs?	If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			te of delivery nnth Day Year	
<u>8</u> 8 8 6	Fart II. Other significant		uting to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ribute to the cause of death? 3 Probably 4 Unknown	'n
		FAIL	IRE					rmed?	Were autopsy findings available prior to completion of cause of death? □ Yes 2□ No	le
ng Phys ther this neral dis	examiner? 1 □ Yes 2 X No	Hosp	oital: 1 Sunpatient 18a. Date of Injury (Month, Day)	28b. Time of	28c. Injur Wor	er: 4 🗆 Nursing H	ath Check only of fome 5 Residence 128d. Describe h			
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer Medical Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	8e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural Route Number,	_
he Hospi in 24 hou he Funer pletely fill edical	one)	Certifying Physicia Medical Examiner:	On the basis of each of and manner state	my kinowledge deat kamination and/or in d.	occurred at the tirvestigation, in my o	ns, date and place pinion, death occu	rred at the time,	date and place,	and due to the cause(s)	
To the trought of the		5. Shive	necedin	D (Item 23a) (Type		3774	C	october	1 (Month, Day, Year)	
State Registrar	PAUL T. 31. Date filed (Month, Da	LIVENC y. Year)	500bmc	Signature	SETON D	PIVE C	UMBE	RLAND	MD 2150)	l

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician ROBERT LEE STULL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yea SEPT. 27, 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 7^(ear)1936 9. Birthplace (State or Foreign **Funeral** Months Days Hours MARYLAND 214-34-1008 69 Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location purmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exant act must be indifficult ones. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND WASHINGTON KEEDYSVILLE Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21756 19060 KEEDYSVILLE ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DAIRY FARM FARMER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN FRANKLIN STULL, SR. CLYDIE M. LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) NANCY L. STULL, SPOUSE 19060 KEEDYSVILLE ROAD, KEEDYSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 10/7/2005 SMITHSBURG, MARYLAND * 4 □ Demation 5 □ Other (Specify) uneral Service Licensee 22. Name and Address of Facility 21. Signature of 7606 OLD NATIONAL Pike Paul M. Dean BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the dis Pan1. Enter the dis section, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiac O minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Physician: The law requires that the death certificate be executed Unknown Due to (or as a Division of Vital Records, P.O. Box 68760, Physician/Medical Y-Rays IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 198 Mauk MD 203// Lappans Rd Bransbase MD. 2/7/3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 6 2005 Registrar

DHMH 17 Rev 1/2001

, -	+ (4	For Amend #10e State of Maryland / Dep			Mental Hygie	2005	33462
	W		Registrar WCHD/SH 10/4/05 per FH 1. Decedent's Name (First, Middle, Last)	rtificate of	Death	Reg	. NG. O O O	3. Time of Death
	Physician	n	Mary Jane Spielman			Month	Day Year	
	/Medica Examine		la. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of De	
			14611 Water Company Rd.		scade			ington
	Funeral Director		5. Social Security Number 6. Sex 1 日 M 2 日 F 84 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y Septembe		irthplace (State or Foreign Country)
		-	Usual Residence of Decedent			Septembe	I 20, P	ennsylvaia
	anylan show	.	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	he Ma	600	Maryland Washington 10e, Street and Number	Casca 10f. Zip Code	ide	100	Citizen of What (1 ☐ Yes 2 🗷 No
	With With De C	<u> </u>	14611 Water Company Rd. 14611 Water Copany Road		21719	100		
	death	nera			Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-	U.S.A 14. Race - An Black, Wi	nerican Indian,
36	or Ite	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ KNo		Thous, etc.,	Consider	
Ö	hours	edp	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occu	pation	16	b. Kind of Busines	White s/industry
215	hin 72	plet	(Specify only highest grade completed) (Give	kind of work done DO NOT use retire	during most of worl	king		,
21	ed wit ygjene yer the	50	12	Homemake			Home	
and	ntal H ed oth	Pe	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	,	
Maryland 21215-0036	should mark mark smartic	<u> </u>	Edward Cecil McGowan 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Stree	Flor t and Number or Ru	ence Dock ral Route Number, (Zip Code)
Σ	alth a		Heather S. Carter (Daughter) 1461	1 Water	Company R	d. Cascad	e, Maryl	and 21719
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural" or items 23e or 28e-f show any injury or other treumatic event, the Meulcal Evaniner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition 1 □ Burial 2 □ **Cremation 3 □ Bemoval from State** 20b. Place of Disposition competery, cre	osition (Name of matory or other pla	ace)	Date 2005 20	c. Location - City of	r Town, State
Ë	t. Pag tment tent: ijury c		`4 □Donation 5 □ Other (Specify) Smithsbu	-	tory Sept	. 30,	Smithsbu	ry, Maryland
Bal	permii Depat Impoa any ir		21. Signature of Funeral Service Licensee 2 22. Signature of Funeral Service Licensee 2 23. Signature of Funeral Service Licensee 2 24. Signature of Funeral Service Licensee 2 25. Signature of Funeral Service Licensee 2 26. Signature of Funeral Service Licensee 2 27. Signature of Funeral Service Licensee 3 28. Signature of Funeral Service Licensee 3 29. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 20. Signature of Funeral Service Licensee 3 21. Signature of Funeral Service Licensee 3 22. Signature of Funeral Service Licensee 3 23. Signature of Funeral Service Licensee 3 24. Signature of Funeral Service Licensee 3 25. Signature of Funeral Service Licensee 3 26. Signature of Funeral Service Licensee 3 27. Signature of Funeral Service Service 3 28. Signature of Funeral Service Service 3 29. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature of Funeral Service 3 20. Signature 5 20. Signature of Funeral Servi	2. Name and Addr			25 Bradbu hsburg.M	
			23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	6/	Co. cim	120		Onset and Death
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ó,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):					
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Box 68	death certificat e attending phy of for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of d	alivery
	death e atter d for t	Clar	in the past 12 months? 1 Ves 2 10 10 4 Pregnant at time of death 5	⊒Ectopic pregnand ☐ Other <i>(specify)</i> _	у		Month	Day Year
P.0	that the death cered by the attending detached for use	hys	9 ☐ Unknown					
		2	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause gi	iven in Part I.			to the cause of death? Probably 4 Unknown
Division of Vital Records,	v requ	Completed				24a. Was an		autopsy findings available
Re	The law ate has page 2 s	d Ho				autopsy performe	d? prior to	completion of cause of
ital	ysicien: The is certificate director, pag	Be C	25. Was case referred to in dical examiner?		26. Place of Dea	1 Yes 24th (Check only one)	No 1 ☐ Ye	15 2 140
of V	Physicien: rthis certifica ral director,	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	III 3LI DOA		ome 5 Residence		ecity)
ou o	ding P	tion:	27. Manney of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	Wo	ury at ork? □Yes 2□No	28d. Describe how	injury occurred	
/isi	of or Attending after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, st			28f. Location (Street	et and Number or F	Rural Route Number,
Ö	tel or rs afte el Dir	Certification:	4 Homicide building, etc. (Specify)			City or Town, S	State)	
	the Hospitel nin 24 hours a the Funerel I npletely filled	edical	29a. Certifier (Check only 1 Certifying Physicien: To the best of my knowledge, deal 2 Medical Exeminer: On the basis of examination and/or in	th occurred at the to	ime, date and place, opinion, death occur	and due to the caus	se(s) and manner a and place, and du	as stated. ue to the cause(s)
	To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Med	oper and manner stated. 29b. Signature and title of certifier	29c. Licen	se number	29d	. Date signed (Mor	nth, Day, Year)
	⊢ s ⊢ ŏ		Atridus V. J. Ind	13	3/27	6	e Mendre	1-30 Dista
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1	^	1 . 1	
SH			3) Date filed (Month, Day, Year) 32. Registrar's Signature	110 mg	weed Co	whos Is	el Her	return
	State Registra		OCT 0 4 2005	rete		A	'	MA

			1 - For State Registrar		Marylar		artmen rtificate			and M		Reg. No	uua	3	341	63
	Physici /Medic		1. Decedent's Name (First, Middle, Frances South Sn								2. Date of De Month Oct.	ath Day	y Yea 2005	r	3. Time of 0	Death A M
4	Examin		4a. Facility Name (If not institution,			440			Location o	of Death			County of De	ath		
			19800 Tranquilit	*		113 last birthday)		1 Year	WIN If Under	24 Hrs.	8 Date of Bir		Washing		o (State or	Fomian
	Funeral Director		579-09-6324 Usual Residence of Decedent	1□ M 25xF	91	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 07/14/			Country	e (State or) MD	roreign
	yland 10w		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d.	Inside City	Limits
	a-fsh	ctor	MD Washing	ton	На	agersto	wn								1 ☐ Yes 2	2 ∑No
	th with the 23a or 28	Funeral Director	10e. Street and Number 19800 Tranquilit	y Circle,	Apt.	113	10f. Zip 21	Code .740				10g. Cit	izen of What (Country	?	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "naturel", or Items 23e or 28e-f show importants if Item 27 is marked other then "naturel", or Items 23e or 28e-f show approximation of the modified at any injury or other traumatic event, fre Medical Exactles frank in indified at ange.		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give	es?		Was Deced If Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - An Black, Wh Specify:			
003	hours turel',	d by	3X Widowed 4 □ Divorced	Year or Date	es:							105 16				
21215-0036	nd 2 should be filed within 72 hours aft alth and Mental Hygliene. 27 is marked other than "naturel", or i r fraumatic event, fra Medicul Exert.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	dent's Usua kind of wor DO NOT us	il Occupa ik done d se retired)	ition <i>luring</i> mosi)	t of worki	ing	160. K	ind of Busines	s/Indus	try	
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Maryland	d be fill hall Hall Hall hall hall hall hall ha	Be	17. Father's Name (First, Middle, La Roy (unk) South	ist)							(First, Middle, unk) Kn		Sumame)			
aryl	should and Me a mark umatic	2	19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailir	ng Address	(Street a			il Route Numbe		r Town, State	, Zip Co	de)	
Ž,	and 2 ealth a n 27 ls		Jeff South / Nep	hew 							encast					
Baltimore,	ages 1 to fr : If Item		20a. Method of Disposition 1 Borial 2 A Cremation 3		ale	Place of Dispo cemetery, crer					-2015		ocation - City o			
ij	artmer ortant injury		' 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fuheral Service Li	A	Sm	ithsbur 22					cald N.		thsburg			omo.
Ba	Depa Impo		Fraul M	Mer							et, Ha)IIIe
	Physician /Medical Examiner		23a. Part1. Enter the disease, dr€ shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a. (12	as a conseq	etu	er the mod	e of dying	g, such as	cardiac o	or respiratory and	rest,		Int	pproximate erval Betwe nset and De	
8760,	certificate be executed triing physician and ise as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq											
P.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Feta nt at time of d	al death 3	Ectopic pro						23d. Date of d Month	elivery Day	у Үө	ar
	requires that the de een signed by the a rould be detached to	d by P	Part II. Other significant condition	s contributing to dear	th but not res	sulting in the u	nderlying ca	ause give	n in Part I.				se contribute □ No 3 □ F			
of Vital Records,	aw s b	Completed by											24b. Were a prior to death?	comple	etion of cau	allable se of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only o	пе)				
o	Phys er this eral di	J: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		Bc. Injury Work	AU Nu		ne 5 ☐ Resid 28d. Describe h			ecify)		
ion	Attending r death. actor: After by the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day Year)	Injury	М		? ′es 2 □ l	No						
Division	el or Atte s after de sl Diracto ed in by th	Certification:	3 Suicide 6 Could no determin	ad 28e. Place of	Injury - At he , etc. <i>(Specif</i>	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tox			Rural Ro	oute Numbe	or,
	To the Hospitel or Attending Physicien: The twithin 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	edical (29a. Certifier Certifying (Check enly one) 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	is of e≱rámina	owledge, death ation and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) date and	and manner a place, and du	as stated	i. e cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier	Λ	/	1	29c	License	number	. 7	> .	29d. Dat	e signed (Mor	nth, Day	, Year)	
			greder!	-//	1		1	70	Si) 4) (20	to be	- 5	u	75
St	1-10		30. Name and address of person with Frederic H. Kass				,	Rd	# 13 0,	Hag	erstown	ı, M	21740)		
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DHMH 17 Rev 1/2001

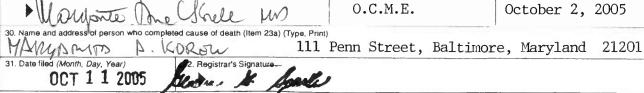
State of Maryland / Department of Health and Mental Hygiene 33464 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Orville Schetrompf September 30 2005 10:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Mary land 77 Yrs. Director 213-24-9835
Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Williamsport Maryland <u>Washington</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itema 23 Funeral <u>16505 Virginia Avenue</u> 21795 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ۵ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sarah Edith Orville G. Schetrompf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tran Michael Shaeffer-Attorney 148 W. Washington St. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Oct.3,2005 Hagerstown Maryland 21. Signature of Soneral Section Lip Osborne Funeralin Home, P.A. 425 S. Conococheague St.Williamsport,MD Inter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disea e or condition seyand Deal Physician resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed that initiated events the attending physician and hed for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 1 Yes 2 No 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Pak II. Other significant conditions contributing to death but no resulting in the under king cause given <u>in Part L</u> à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month/Day, Year) Uncom 3H-10 32. Registrar's Signature State Registrar

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-	For Unpend State Unpend Registrar	Item	State o 23a&27	of Maryla per m	and / Department of Fee G849 1173-05 of	lealth and Mental Death	Hygiene 0	05	3	3

Al	KG		1 - State Unpend Item Registrar	State of M 23a&27 pe	larylar er me	nd / Dep G849 <i>e</i>	artment 113-0 rtificate	of H	ealth and <i>Seath</i>	d Mental H	ygiene Reg. No.	005	33465
	Physic /Medi		1. Decedent's Name (First, Middle, La							2. Date of I	Death	005 ^{ear}	3. Time of Death 2:16 P M
	Exami		4a. Facility Name (If not institution, giv Atlantic General)		4b. City, 1 Berl:		Location of De			onty of Death Cester	
	Funeral Director		5. Social Security Number 6. S 217-80-4007 1 Usual Residence of Decedent	ex 7. A □M 2 X F	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. (Month,	Birth Day, Year) 28,195	Co	nplace (State or Foreigi untry) irginia
	Maryland f ehow	tor	10a. State 10b. County Maryland Worces	ter	10c. Ci	ity, Town or Lo							10d. Inside City Limits
	3a or 28a	i Director	10e. Street and Number 12301 Jamaica A	Un:	it-31	1	10f. Zip	Code 2184	2		10g. Citizen	of What Co	,
036	ours after death ral', or iteme 2 Exerciment	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	t Ever in U	J.S. 13.		ent of His fy Cubar		(Specify Yes or lento Rican, etc.)	No- 14. I	Race - Ame Black, White ecify: B1	ncan Indian, o, etc.
21215-0036	d within 72 ho giene. or then "natur the Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 2 years	5+)	(Give	dent's Usual kind of work DO NOT use	done di retired)	uring most of v	vorking		f Business/I	ndustry
Maryland	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) James Edward	Sweeney			·		18. Mother's N	lame (First, Midda) Jane	Moore	name)	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Gloria Moore () 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Licer	Aunt) Removal from State /)	, '	25 W Place of Disponentery, cred 111ams	est 13 position (Nammatory or other Memoral Name and Wesle	B2nd e of ther place cial Address ey Cl	Street Oct Park of Facility havis	:Apt.151 .8,2005 	20c. Location Roan	ork,Ne on-City or T oke, V	own, State /irginia Inc.
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ofications that cause one cause on each a. Alcohol Due to (or a:	ine. .ism	th. Do not ent						Wash.I	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury that initiated events	b. Due to (or as	s a conseq	quence of):							
68760,	ficate be executed physicien and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consequence of): d.									
P.O. Box 6	The law requires that the death certific site has been signed by the ettending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ıldeath 3 ☐	∃Ectopic pre ∃ Other (spe					Date of deli Month	very Day Year
rds, P	w requires that been signed t should be deta	þ	Part II. Other significant conditions o	ontributing to death	but not res	ulting in the u	nderlying ca	use giver	n in Part I.		Yes 2 No		the cause of death?
Division of Vital Records,	The law requirate has been page 2 should	Completed							· · · · · · · · · · · · · · · · · · ·	24a. Wa aut per 1 Yes	is an 24 opsy formed? 2 \(\begin{array}{c} 24 \\ 2 \end{array}	b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of 2□ No
<u> </u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				7		eath Check only			
on of	Attending Physicien: r death. ector: After this certification; by the funeral director.	ıtlon: To	1 Xyes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Ho					sidence 6 ((y)	
Divis		Certification:	3 Suicide 6 Could not be determined		jury - At he tc. <i>(Specit</i>	ome, farm, str (y)	eet, factory,			28f. Location City or T	(Street and Nu own, State)	mber or Rui	al Route Number,
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the bank liner: On the basis of and manner s	of examina	wladge, daet ition and/or in	h occurred al vestigation, i	the time n my opi	a date and pla nion, death oc	curred at the time	e causs(s) and a, date and plac	e, and due	state u. to the cause(s)
)	To the within 2 To the comptet	Σ	29b. Signature and title of certifier	x . (16.	0 0	IN		License O.C.	number M.E.		29d. Date sig Octobe		

State Registrar



			1 - For State Registrar	State	of Maryl	and / Depa	artment of I rtificate of	Health a <i>Death</i>	and Me		en 0 0	5	3346	56
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 28 2005 0745										Death M	
	Examin	er	4a. Facility Name (If not institution, Anne Arundel Med 5. Social Security Number	4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs. 8 Date of			8. Date of Birth	4c. County of Death Anne Arundel Birth Day, Year) 9. Birthplace (State or Foreign Country)						
	Director		220 30 5164 Usual Residence of Decedent	1□M 2 ⊠ F	69	yrs. last birthday) Yrs.	Months Days	Hours	Min.	(Month, Day, March 3	,1936		uryland	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, the Medical Evantinal trained to collified at once.	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Bowie 10t Zin Code 10a Citizen of What Country?											
			2405 Kinderbrook						og. Citizen of Wh United					
Maryland 21215-0036		by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:					14. Race - American Indian, Black, White, etc. Specify: White		
		To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Hairdresser Assis							g 1	6b. Kind of Busi	f Business/Industry		
			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid											
			19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street				City or Town, Si	ate, Zip	Code)	
Baltimore, N			Bernard Scherr/Husband 2405 Kinderbrook Lane Bowie, MD 20715 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Beth Yehudah Cemetery 9-30-2005 Baltimore, MD											
Baltir			21. Signature of Funeral Service Li			L044 22	Name and Addre	ss of Facilit	Harry	y H. Wit	zke's F	ami.	ly FH I	
ords, P.O. Box 68760,	ding Physician: The law requires the name of the continuate has been signed funeral director, page 2 should be detected.	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, If the latest or injury that initiated events resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
		Physician/Medicai	d								23d. Date of delivery Month Day Year			
		Completed by	Part II. Other significant conditions				\ \ /	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown						
Vital Records,										24a. Was an autopsy performe	prio	or to con th?	psy findings ava npletion of caus 221 No	
of		ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of D att 1 Natural 5 Pending investigat	28a. D e (Mon	lospital: Other					eath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Division	al or Atta s after des ll Diracto d in by th	Certification:	3 Suicide 6 Could not determine	ad 200. Place						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attantwithin 24 hours after deati To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
ļ	To the within 2 To tha complete	Ň	29b. Signature and title of certifier Jelenene Wein MD DS 7 8 3 0 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeline Wein 900 Bestgafe Road #300 Anneys (15) 31. Date filed (Month, Day, Year) 32. Expisitrar's Signature 4 Anneys (15)							d. Date signed (Month, Day, Year) SEPTEMBER Z8, Z005				
Ole	7		30. Name and address of person who Segnine Wer	o completed caus	se of death (I	tem 23a) (Type, I	Print) Cood #	320	Ann	900/15	MO	7	1401	
	Sta Registra		31. Date filed (Month, Day, Year) OCT 0 3	2005	gistrar's Si	gnature	radio			-9 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 05 For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SEPTEMBER 27, 2005 BRENDA LOUISE 11:50P SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES BRADFORD OAKS NURSING HOME CLINTON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2**V**□ F 50 Director MARCH 5. 212-66-9405 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b Counts 10a State 28e-f show Examiner count be notified at 1 ☐ Yes 2 📉 No Director MD CHARLES LAPLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 7545 ANNAPOLIS WOOD ROAD 20646 UNITED STATES Items 23g Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XXNo 1 Never Married 2 Married 6 1 ☐ Yes 2 🕅 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATIVE SECRETARY BUSINESS 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be and Mental PEARL GUTRICK SMITH SYLVESTER SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 struction of Health and ant: If item 27 Is r 7545 ANNAPOLIS WOOD ROAD, LA PLATA, MARYLAND 20646 PEARL SMITH/MOTHER permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) OCTOBER 3, 2005 NANJEMOY, MARYLAND MT HOPE CHURCH CEMETERY re of Funeral Convoc Line THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 INDIA C. THORNTON JOHNSON Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CALGNOM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ò 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à The law requires that signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à pe 2 No 3 Probably 4 Unknown 1 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗆 No certificate 2 No 1 Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1 Tyes this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 5 Pending investigation 14 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in 24 hours a Puneral I Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical npletely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

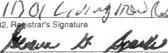
Division of Vital Records,

Date filed (Month, Day, Year)
SEP 3 0 2005

(Mi)

n

30. Name and address of pers



on who completed cause of death (Item 23a) (Type, Print)

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Aubrey Lee Smith 1, October 2005 8:55a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**½** M 2□ F Months Director 226-48-5737 65 17,1940 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 'natural', or Items 23a or 28a-f show dical Examiner must ke notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Cecil Elkton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 378 Muddy Lane Completed by Funeral 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or Ite 1 Never Married A Married I Tyes 2 No
If Yes, Give
Year or Dates: 1960 's Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Steel Fabricator Mid Atlantic Steel 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Oscar Con Smith Georgia Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie P. Smith 378 Muddy Lane, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Importent; If any injury or once. R.A. Ferris, Inc. October 6, West Chester, PA 22. Name and Address of Facil 2005 2 Signalure of Finery Service Licensee TO Andrew G. Gee Funeral Home 23a. Parti. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 59 E. Main st., Elkton, MD rithe mode of dying, such as cardiac or respiratory arrest, 21921 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse Examiner Sequentially list conditions, I any Leading to the cause. Enter Underlying Cause, Disease or injury that initiated events Examiner Dualto (or as a consequence of): use as the burial-transit The taw requires that the death certificate be executed the attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death P.O. 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TMo this 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062643 ted cause death (Item 23a) (Type, Print) () nia Kacen 3 State Registrar

			For 1 State	State of Ma	ryland / Depa	artment of H			iene 2005	33469
			Registrar 1. Decedent's Name (First, Middle, Las	st)			704177	2. Date of Deat	3	3. Time of Death
	Physici	an		stanley	Seabrigh	t		Month	Day Yes	M
	/Medic		4a. Facility Name (If not institution, give		Ocabrigit		Location of Death	occober	10, 2005	
	Examin	er				Cumberla	_		Allegan	
			Memorial Hospital 5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			DM 2DE	9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 22,	1926	Country)
			Usual Residence of Decedent		<u> </u>			, .ug,	1020	
	/land		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Man f sh	tō	WV Hamsp	hire	Capo	n Bridge				1 □Yes 2□No
	1 the	rec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
	3a o	Funeral Director	HC 71 Box 105F			2	26711		USA	
	ms 2	Jer.	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-		merican Indian,
ထ	after or ite		1 Never Married 2 Married	1, Yes 2 N	0	1 □ Yes 2 No	Specify:	nican, etc.)		hite, etc.
8	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1944-46	10 165 20 100	Зреспу.		Specify: W	hite
9	72 hc netu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occupa	ition Juring most of work	ina	16b. Kind of Busine	ss/Industry
7	thin thin	nple	Elementary/Secondary (0-12)	College (1-4or 5	+) !	kind of work done d DO NOT use retired;	,	i		
7	ygien ygien yer th	S	11		Range	Officer			J.S. Gov.	FEMA
p	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23a or 28e-f show event, it a Madical Evain are must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	should be fand Mental I	၉	Arthur S. Seabri					Forema		
ar			19a. Informant's Name/Relationship (Laura Seabright	Type, Print) wife		ng Address (Street a				e, <i>Zip Code)</i> NV 2 6711
2,5	1 and 2 Health tem 27			WIIC	20b. Place of Dispo			•		
ore	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	matory or other place	9)		20c. Location - City	
Ë	ment ment tent:		* 4 □ Donation 5 □ Other (Specif		Mt. Hebron				Winchest	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Depertment of Healt Importent; if item 2 eny injury or other once.		21. Signature of Funeral Service Licer	isee Ma						me, PA for
_	₹0 = 9 d		110000	2/1//		Jones Fund				
			23a. Part1 Enfer the disease, or com shock, of heart failure. List only	plications that caused one cause on each lin	the death. Do not ente.	ter the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Pulma	nary E	mbolis	\sim			sudden
	/Medical		resulting in death)		consequence of):					
	Examiner		Sequentially list conditions.	b						
l.	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	acute trans	am	Cause (Disease or injury that initiated events resulting in death) Last	C						
80,	oe ex	û	Todaking in dodkin, Eddi	Due to (or as	a consequence of):					
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dical		d						
9	death certifica attending ph d for use as th	Me	IF FEMALE:	22- 15						
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetel death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0.	the a	Physician/Me	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death 5L	Other (specify)				
<u>.</u>	that the ded by the detached		Part II. Other significant conditions of	contributing to death by	it not resulting in the u	nderlying cause give	an in Part I	23e. Did tob	acco use contribute	to the cause of death?
Ś,	ires that signed b	by	Seizure		or not rosalling in the d	riddiny mig odddod give				Probably 4 Phiknown
oro	w requir been si should	ted		D1301961						
Records,	aw as b	Completed						24a. Was ar autops	y prior	autopsy findings available to completion of cause of
H	Th ate pag	Co						perform 1 Yes 2	led? death	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ttind		04	26. Place of Deatl	h (Check only one	3)	
	Physicien: this certific ral director,	2	1 □ Yes 2 No	Hospital: 1 Inpatie			4 Nursing Ho		nce 6 Other (5	pecify)
n	ling P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)		Work	(?	28d. Describe ho	w injury occurred	
sio	Attending in death. sector: After by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b				res 2 □No	005 11 /04		D - 1 D - 1 N - 1
Division of	or Attendations after death	Certification:	4 Homicide determined	building, etc	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		City or Town		Rural Route Number,
	urs a		0 .:: 15A .:: 1							
	To the Hospitel or Attending i within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exal one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	n occurred at the tim vestigation, in my or	ie, gate and place, pinion, death occurr	and due to the cared at the time, da	ite and place, and	as stated, due to the cause(s)
	thin the	Med	29b. Signature and title of certifier	and manner sta	ned.	29c. License	number	29	9d. Date signed (M	onth, Day, Year)
	N N N		\$ 5	71					10/11	NME
,	0		()m	Mho	m	D54004	4		10/10	103
11	57		30. Name and address of person who				T 1	MD 01500		
	- 01		Shiv C. Khanna, N	32. Redistra	-E Nallona. ar's Signature.	n n n g n way	, Lavale,	rm 21502		
	Sta Registi		OCT 1 4	2005	ar's Signature	your				

		-	For Stete Registrar	State of Maryland / I	Depa <i>Cer</i>	artment of He tificate of D	ealth and M <i>eath</i>		2005	33470
	Dhi.ai		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	al	Charles H					Septembe	r 29, 200	
7	Examin	er	4a. Facility Name (If not institution, give :			4b. City, Town, or L Chesapeal			4c. County of Dea	
	E		2620 Richfield La 5. Social Security Number 6. Sep		rthday)	-	If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign ountry)
	Funeral Director			JM 2□F 78	Yrs.	Months Days	Hours Min.	Month, Day, Y Dec. 25.	1926 I	ountry) Ll inoi s
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or to	nation				10d. Inside City Limits
	ahov	ō	MD Calvert C			e Beach				1 X Yes 2 □ No
	the N	rect	10e. Street and Number	our of order		10f. Zip Code		100	. Citizen of What C	ountry?
	3a or	Ö	2620 Richfield Lan	e		20732			U.S.A.	
	death	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No-	14. Race - Am Black, Whi	
98	or lite	y Fu	1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give			Specify:	,,		White
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow Iteal Exacultur fresh by motified at	ed by	3 Widowed 4 Divorced	Year or Dates:	Deced	lent's Usual Occupati	ion	16	b. Kind of Business	
15	in 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done du OO NOT use retired)	ring most of workir	ng l		
212	ad with	m C	12		lnsu	rance Ager			nsurance	Company
P	ba file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name		iden Sumame)	
Maryland	d Man narke natic	ဥ	Arthur Smith 19a. Informant's Name/Relationship (Ty	Tolera Driet	h Mailin	g Address (Street an	Ethel Ma		Situate Town State	Zie Codel
<u>≅</u>	d 2 st th and traun					Richfield				
ē,	s 1 an f Heal item 2		June C. Smith (Wi 20a. Method of Disposition	20b. Place of	of Dispo	sition (Name of natory or other place)	Onto		c. Location - City or	Town, State
altimore,	Pages ient of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		Vets. Cem.			eltenham,	Maryland
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any fujury or other traumatic event, the Maclical Exa. diner can be notified at once.		21. Signature of Edberett Service Livens	90	22	. Name and Address	of Facility Lee	Funeral	Home Calv	vert, P.A.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do		25 Souther of dying,				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LUNG CA	NCE	R				Onset and Death 3 MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a consequence	-					0 14.07077.3
	Examine	er	Sequentially list conditions,	Due to (or as a consequence	of):					
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dub to (or as a consequence	01).					
Ć	be executed sician and burial-transit	Examin	resulting in death) Last	Due to (or as a consequence	of):					
8760,	cate be ex physician the buria	dical		d,						
9	ertifica ling ph	Med	IF FEMALE:	3c. If yes, outcome of pregnancy						
Вох	law requires that the death certific as been signed by the attending f 2 should be detachad for use as	by Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.	that the death led by the atter detachad for u	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
۳,	res that igned b	y PI	Part II. Other significant conditions con					23e. Did tobac	cco use contribute t	o the cause of death?
ords	w raquira baan sig should b	ted	CHRONIC OBSTRUC	CTIVE PULMONI	gry	DISEA	958	1 X Yes	2 □ No 3 □ P	robably 4 Dunknown
ecc	has be	Completed						24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
<u>e</u>	The ate							performe 1 Yes 2 \$		2 □ No
Vita) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	. do adi an	Other	26. Place of Death		ce 6 □Other (Spe	
of	y Phye er this eral dir	n: To	27. Manner of Death	28a. Date of Injury 28b.	Time of	28c. Injury a Work?		8d. Describe how		cuy)
ion	Attending For death. ector: After by the funer	atio	1 Natural 5 Pending investigation	(MONIN, Day 10al)	Injury		es 2 □No			
Division of Vital Records,	or Atter ter de irecto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, str	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or A State)	ural Route Number,
	Hospitel or 24 hours afte Funeral Dir tely filled in	Ce	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledg	o death	occurred at the time	date and place a	nd due to the caus	co(c) and manner a	e etatod
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical Exami	ner: On the basis of examination a and manner stated.	nd/or in	estigation, in my opin	nion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License i		29d	. Date signed (Mon	th, Day, Year)
			Man DV	M.D.		D40	370		9/29/0	5
,	N 11		30. Name and address of person who co				77.2			0055
1	0+1		Peter L. Wisnie 31. Date filed (Month, Day, Year)	WSKI M.D. 1084	15 T	own Center	r Blvd.,	Dunkirk,	Maryland	20754
	Sta Regist		SEP 3	32. Registres Signature	K	goode				

			For State Registrer	State of Marylan		artment of H			ene 2005	33471
	Physici	_	1. Decedent's Name (First, Middle, L.	SANTAREL	<u></u>			2. Date of Death Month	Day Year	3. Time of Death
	Examin Funeral Director	er		Sek 7. Age (In yrs 1 2 F	Or-tal last birthday) Yrs.	4b. City, Town, or Purchase 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth		
	Maryland -f ahow live at	tor	10a. State 10b. County PA York		y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2☑ No
	with the sor 28e	Direc	10e. Street and Number		JIK	10f. Zip Code		10	g. Citizen of What C	ountry?
36	s after death , or Itams 23	by Funeral Director	1140 Hearthr 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give				Specify Yes or No- to Rican, etc.)	USA 14. Race - Am Black, Whi Specify: W]	te, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23s or 28e-f ahow any injury or other traumatic avant, I're Medical Extractional to the Italia of an exercise.	Completed b	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	rade com <i>pleted)</i> College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	during most of wa f)	rking	6b. Kind of Business	ŕ
	d be filed v antal Hygie ted other t c avent, ID	Be	12 17. Father's Name (First, Middle, Last John L. San		Analy	tical (18. Mother's Na	<u>P</u> me <i>(First, Middl</i> e, <i>M</i> Shaw	lanufacti aiden Sumame)	ırıng
Maryland	nd 2 shoul Ith and Me 27 is mark r traumati	P	19a. Informant's Name/Relationship Amy Santare	(Type, Print)		•	and Number or R	ural Route Number,	City or Town, State,	
Baltimore,	Pages 1 ar lent of Hea nt: If itam ry or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	emetery, cren	sition (Name of natory or other plac NCIS Cen			oc. Location - City of Gettysbur	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Lice		22	. Name and Addres	ss of Facility J	.L. Davi	s Funera	al Home
	Pnysician /Medical		23a. Paw. Shift the disease, or conshock, or heart failure. List online disease or condition resulting in death)	mplications that caused the death y one cause on each line. a	15	er the mode of dyin	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	uence of):	MULTIFO	RME		ų.	180 days
P.O. Box 687	ne death certific the attending p thed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	Se un eo	by	Part II. Other significant conditions	contributing to death but not rest	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	,	o the cause of death?
I Records,	The taw ate has b page 2 st	Completed						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Oth	or	ath (Check only one) nce 6 ☐Other (Spe	acify)
ion of	ding h. After fune	ertification: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury	28c. Injun Worl		28d. Describe how		,
Division	ital or Attars after de al Diracto	Certific	3 Suicide 6 Could not 4 Homicide determine			eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Executed Medical Executed Property 2	Physicien: To the best of my kno eminer: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in my o	pinion, death occ	urred at the time, da	te and place, and du	e to the cause(s)
)	To To con	2	29b. Signature and title of certifier				- COO		TOBSE 4	_
	10		30. Name and address of person what will address of person when the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of person who are the same and address of the same address of t				BALTIMO	ex, MD Z	1287	
Ng.	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 4	32. Bagistrar's Signa	ture	ode				

State of Maryland / Department of Health and Mental Hygier 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Clifford Shives Oct. 6, **Physician** ^{Day}0 0 5 Year 15:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany County Nursing Home Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Country) | Nonths | Days | Hours | Min. | Apr. | 15, 1900 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F 705-05-4460 Director 105 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Allegany Cumberland 1 ☐ Yes ঠ ◯ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Furnace Street 21502 USA or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1942
If Yes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filad within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Freight Station Railroad Pages 1 and 2 should be filad v nent of Health and Mental Hygie int: If item 27 Is finarkad other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Shives Katherine (Myers) Shives 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Cameron Daughter 12801 Hannah Dr NE, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) ö Rocky Gap Vet Cem Oct.11 05 Flintstone, MD 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licenses 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause project line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Kidney Disease Physician 10 Yrs. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 I No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a Was an autopsy performed? Division of Vital 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. within 2 the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D-14865 Oct. 8, 2005 Somy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Robustiano J. Barrera, MD 500 Memorial Ave Ste 201, Cumberland, MD 31. Date filed (Month, Day, Year) Registrar's Signature State 21502 Registrar OCT 1 4 2005

			1 - For State Registrar		artment of Health and Martificate of Death	lental Hygie	711115	33473
•	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal		OMS		SEPTEMBER		12:50 P
	Examir	ner	4a. Facility Name (If not institution, give street at 134 LAKIN AVENUE	na number)	4b. City, Town, or Location of Death BOONSBORO		4c. County of Death WASHING	TON
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		ace (State or Foreign
[Director		220-09-7732	89 Yrs.	Worldis Days Flours Will.	MAY 19, 1		ŽLAND
land	Mo #		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10	Od. Inside City Limits
Mary	He la	tor	MARYLAND WASHINGTON	ı	BOONSBORO)		1 X Yes 2 □ No
ith the	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		Citizen of What Count	ry?
ath w	8 23a	rai	134 LAKIN AVENUE	B 10 10 10 10 10 10 10 10 10 10 10 10 10	21713		U.S.A.	
ter de	tem ner	Fune	Am	s Decedent Ever in U.S. 13. Ved Forces? Yes 2 17 No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	
III C I C I S I S I S I S I S I S I S I	al.	þ	If Yo	es, Give	1 ☐ Yes 2 🙀 No Specify:		Specify: W	HITE
72 hc	natu	Completed	15. Decedent's Education (Specify only highest grade complete	leted) (Give	dent's Usual Occupation kind of work done during most of worki	ng 16b	. Kind of Business/Ind	ıstry
within	than	dmc	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	PARTS HANDLER	ΔТ	RCRAFT MAN	TEACTIBE
pelii e	Hygiene othar tha rent, tre	a	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		OFACIONE
should be	Mental arked o	To B	EARL WEBSTER MICHAEL	SR.	MAMIE EL	IZABETH V	IOLET	
F &	ls my		19a. Informant's Name/Relationship (Type, Prin		g Address (Street and Number or Rura			
1 and	f Heelth and Mental Hygiene. item 27 is marked other than *natural', or items 23a or 28e-f show other traumatic event, fre Modical Exertirer mail be notified at		KAREN E. SHIFLER/DAUG 20a. Method of Disposition	20b. Place of Dispos	sition (Name of	SBORO, MA	RYLAND 21 Location - City or Tov	713 vn. State
Pages	ent of ht: If in ry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal	from State	natory or other place) O CEMETERY 10/03			
permit. F	Department of Heelth a fimportent: If item 27 Is any injury or other tra-		21. Signature of Funeral Service Licensee	22	. Name and Address of Facility		ONSBORO, M National P	
i 8.	any population		tout 1/ /lav	Paul M. Dean BA	AST HEINHRAL HIKKIH		, Maryland	
			23a. Pa 1. Enter the dis 4.54 or complications shock, or heart failure. List only one cause	e on each line.	- 11 C	7 /		Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	Conges	eme Heart	far ine		Monts
	aminer			Ar Ario (or as a consequence or):	line Heat	disea	2 '	years.
T.		ner	r any resound to immediate	ue to (or as a consequence of).				-
be executed	and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):				
5 8	hysician and the burial-transit	cai E		20 10 (01 20 2 0011004201100 01).				
tificate	g physias the		0	1921				
th cert	r use	an/M	23b. Was decedent pregnant	s, outcome of pregnancy Live birth 2 Petal death 3	Ectopic pregnancy		23d. Date of delivery	
. e dea	the at hed fo	Physician/Med		Pregnant at time of death 5 Unknown	Other (specify)		Month E	Day Year
that th	signed by the attending p d be detached for use as		Part II. Other significant conditions contributing	g to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
duires	n sign uld be	ed by	Awtic S	Levosis, H	ypertensi'n	1 🗆 Yes	2 No 3 Probal	oly 4 🕰 Unknown
law re	as been si 2 should l	Completed	Dene	Tig	<i>y</i> ·	24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
The	n. After this certificate has b funeral director, page 2 s	Com				performed	? death?	□ No
v ILC	certific rector	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death			
Phys	n. After this funeral di	To To	27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ EP/Outpatient Date of Injury (Month, Day Year) 28b. Time of Injury		ne 5 🛣 Residence 8d. Describe how in		
nding	ath. r: Afte ie fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
or Atta	iractor: ractor: r by the	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural i	Route Number,
Pite C	eral Deral Dilled in		29a. Certifier **Certifying Physician: 1	To the heat of my knowledge death			(-) 1	
To the Hospitel or Attanding Physician: The law requires that the death certificate	within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or invitation stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	d at the time, date a	and place, and due to the	ed. 1e cause(s)
To th	To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Da	
Al	5		momen	-	D34165	Se	pt 29Th, 2	005
5			30. Name and address of person who completed MoHAMMED. S	ALI 20311	(APPANS Road	Booms	mo, MD.	21713
	Sta Registr		31. Date filed (Month Car. gar 2005	32. Registrar's Signature	ente			

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itema 23a or 28e-f ahow any injury or other traumatic event, the Medical Everither must be notified at

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

		1 - For State Registrar	State of Marylar		rtificate of			. N20	05 33474
Physic	ian	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day	3. Time of Death
/Medi	cal	Kenneth Eugene]			4h Cihi Taum a	and another of Doroth	Septembe	er 29,	
Exami	ner	4a. Facility Name (If not institution, given Washington County			Hagersto	or Location of Death		Washin	
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Director		214-82-3081	1X M 2□ F 48	Yrs.	Working Days	110013	Sept. 6		Maryland
≥		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation				10d. Inside City Limits
iffed a	वृं	Maryland Washingt	on Boo	nsboro)				Y☐Yes 2☐No
or 28	Funeral Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Country?
a 23a	eral	18521 Breathedsvi	11e Rd	S 112	21713	Hispanic Origin? (Sp	US	1	e - American Indian,
ritem	Fune	11. Marital Status 1 Never Married	Armed Forces? 1 ☐ Yes 217 No		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		ck, White, etc.
P. E.	þ	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1□ Yes 2√√ No	Specify:		Specify	White
natu	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work		6b. Kind of Bu	usiness/Industry
than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Guar	-	۵)		Correct	-fonal
Department of Heelin and Mental Hygiene. Important: If Itam 23a or 28e-f show important: If Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant. If a Medical Evantical must be notified at once.	BeC	17. Father's Name (First, Middle, Las)	Guar		18. Mother's Nam	e (First, Middle, M		
Menta arked	2	William E. Tracy				1	e McGarve	•	
h and 7 is m		19a. Informant's Name/Relationship Gail Tracy/Wife	Type, Print)			and Number or Run dsville Re		•	_ '
Heelt am 2 othar		20a. Method of Disposition	20b. I	Place of Dispe	osition (Name of				City or Town, State
ent of nt: if ii ry or o		to Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	JHemoval from State	•	matory or other place n Cemete:	1	-2005 F	lagerst	own MD
Departm imports any inju		21. Signature of Funeral Service Lice	nsee			ess of Facility Re			
88 5 8		> 5. Winde Si				sylvania .			
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiple 1	njuvi	25				
xaminer			Due to (or as a consec	tuerice (i).					
=	je.	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	r(to eoneug					
end Il-transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	mence ot):					
sicien	cai E			(461100 01).					
g phys			. d						
ste has been signed by the attending physicien page 2 should be detached for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1□Live birth 2□Feta		DEctopic pregnance	v		1	te of delivery
by the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o	death 5	Other (specify)			Мо	nth Day Year
ed by detac		Part II. Other significant conditions	contributing to death but not re-	sulting in the c	anderlying cause giv	ven in Part I.	23e. Did toba	cco use cont	ribute to the cause of death?
been signed to should be deta	d by						1 ☐ Yes	2 1 No	3 Probably 4 Unknown
s bee 2 shor	ompleted						24a. Was an	24b. \	Were autopsy findings available
certificete has irector, page 2	Com						autopsy perform 1D Yes 2	ed?	prior to completion of cause of death? I A Yes 2 □ No
sertific ector,	Be	25. Was case referred to medical examiner?	Hospital		0#		th (Check only one)	
r this c	P	1 ⊈Yes 2 □ No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	III 3LI DOA		ome 5 Residen		
thin 24 hours after death. o the Funeral Director: After this certifical empletely filled in by the funeral director.	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	5= 35	Wor	rk? Yes 2 No	Driver of	motor v	rehide struck
er dea	tifica	3 Suicide 6 Could not determined	De Jan Place of Injury At h	ome, farm, st	* /		28f Location (Stre	et and Numb	er or Aural Route Number - 26 Jefferson 131 vd
rai Di				Road			Hugersto.	Wn V	Ucshington
Fund Fund tely f	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the best of my kn- miner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, dat	ise(s) and ma e and place, a	anner as stated. and due to the cause(s)
A (4 = 0)									

3H-1

LI LING 31. Date filed (Month, Day, Year) State OCT 0 1 2005 Registrar

29b. Signature and title of certifier

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 30, 2005

			1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artmer rtificat	nt of H	ealth a Death	and Me		giene Reg. No.	0 -	3	347	5
3	Physici	_	Decedent's Name (First, Middle, La		TLOR						Date of De Month	Day	7, 700	ear	3. Time of De	
	/Medic Examin		4a. Facility Name (If not institution, give Shady Grove A		1	0		Town, or	Location o			4c.	County of 1	Death	7	
·	Funeral Director		216-01-4105	Sex 7. A 1 □ M 2 X F	ge (In yrs. 88	last birthday) Yrs.	If Unde Months	Days	If Under: Hours	Min. J	Date of Bird (Month, Da an . 1 2	th iv, Year) 2 , 1 9	9. 17 M	Countr	(State or Fo	oreign
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Monto	gomery	10c. Cit	y, Town or Lo	ilve	r Sp	ring	J			1	10	d. Inside City L	
	3a or 28a-	i Director	10e. Street and Number 9701 - Veirs I	Orive			10f. Zi	Code 2 C	850			10g. Citi	izen of Wha		y?	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28s-f show or other traumatic event, the Medical Examinar must be multified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 K If Yes, Give Year or Dates:	?		Was Dece If Yes, spe		spanic Origin, Mexican	gin? (Specif , Puerto Ric	fy Yes or No can, etc.))•	14. Race - Black, \ Specify:	White, e		
Baltimore, Maryland 21215-0036	within 72 ho lene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	life.		ork done d ise retired	lurina mosi	t of working		16b. Ki	of Busin		istry	
/land	should be filed and Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Las. James G. Ta	_							First, Middle, Bischr		Sumame)			
, Mar	and 2 sho saith and n 27 is ma		19a. Informant's Name/Relationship Kristi Hughes		or						ckvi					
more	Pages 1: nent of He ant: If iten ary or oth		20a. Method of Disposition **D Burial 2		C	Place of Dispo emetery, crei ar Hi	matory or	other plac	ery-	Dat -10/3			cation - Cit Ltimo	•		
Balt	permit. Page Department Importent: If any injury or		21. Signature of Funeral Service Lice				HVC	ona	CO.	Tnc	NITAT T	ija ah	, DC			
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	ed the death	h. Do not ent	ter the mo	de of dying	g, such as	cardiac or r	espiratory a	rrest,	1.,00		Approximate nterval Betwee Onset and Dea	
8760,	Medical Examiner bhysician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Non- Due to (or a c. Due to (or a d.		ence of):	on A	Tyo co	ce Die	20 In	fore	tion				
.O. Box 6	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ❤️No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	Ideath 3[]Ectopic p] Other (s						23d. Date o Month		y Day Yea	ır
<u>α</u>	quires that n signed b ıld be deta	by	Part II. Other significant conditions Acute Ronal	contributing to death	but not res	ulting in the u	indertying	cause give	en in Part I.			obacco u Yes 2	_	te to the	cause of deat	
of Vital Records,		Completed	Atrial Fibrill	ation									prio dea	r to com th?	sy findings ava pletion of caus	ulable se of
/ita	Physician: 1 this certifical ral director, p	Be (25. Was case referred to medical examiner?	ļ.,						of Death (Check only o	one)				
=	Physi this c al dire	၉	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpatier			4 🔲 INU		5 🗆 Resi			Specify)		
ion	ding h. After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	28b. Time o Injury	M	28c. Injury Work 1 🔲 '	rat ⟨? Yes 2 □		d. Describe i	how injur	y occurred			
Division	i Qite	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place of I	njury - At ho atc. <i>(Specif</i>	ome, farm, sti y)	reet, facto	y, office		28	f. Location (: City or To	Street an wn, State	d Number (or Rurai	Route Number	5,
	To the Hospitei or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Example)	hysician: To the bes miner: On the basis and manners	of examina	wledge, deat tion and/or in	h occurred evestigation	at the tim	ne, date an pinion, dea	d place, and th occurred	d due to the at the time,	cause(s) date and	and manne d place, and	er as sta	ted. the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifien	13				c. License		#Province	1		te signed (A		-	-
1	(2)		30. Name and address of person whe	completed cause of	death /Iten	n 23a) (Type				987		Sept	ember	2+,	2005	
1/2	3		ROBERICK KG	eisberg 1	1.7	9901	Moc	dical	Cont	en Don	ve, R	ockul	le, Me	ofra	rd 20	1280
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signa	Lure	1									

			For State	State of Marylar	nd / Depa	ırtme	nt of H	lealth and Death	-	/giene	_	
			Registrar 1. Decedent's Name (First, Middle, Last,		Cer	unca	ite oi i	Death	2. Date of D		.003	3. Time of Death
п	Physicia		CARRIE LEE TOOME						SEPTEM	BER Day	Yea Yea	55 (1:50FM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	r Location of Dea			County of De	
	-Adillin	•	BRADFORD OAKS NURS	SING & REHAB	CENTER		$_{ m CL}$	INTON			PRINC	E GEORGES
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Und	ler 1 Year	If Under 24 Hrs Hours Min		irth ay, Year)		Birthplace (State or Foreign Country)
L	Director		244 12 6162 Usual Residence of Decedent	90	Yrs.				JUNE 2	2, 19	915 NO	ORTH CAROLINA
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary First	tor	MARYLAND PRINCE (SEORGES CI	LINTON							XX Yes 2 □ No
	or 28e	Director	10e. Street and Number	SHOROLD C	dinion	10f. Z	ip Code			10g. Cit	izen of What	Country?
	23a c	ai D	7520 SURRATTS ROAL)				20735	,	UI	NITED :	STATES
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Dec	edent of Hoecify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ar Black, W	merican Indian, hite, etc.
36	rs afte	by F	1 Never Married 2 Married XX Widowed 4 Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:				Specify:			Specify:	BLACK
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show he Medical Enerth at must be indiffed at	ed t	15. Decedent's Edu		16a. Deced	lent's Us	ual Occup	ation		16b. K	ind of Busine	ss/Industry
212	hin 72	piet	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of v	vork done d use retired	during most of wo	orking			
21	er tha	Completed	5TH	00.000 (1.40101)	H	IOME	MAKER				DOMES	STIC
Ind	be file d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	e, Maiden	Sumame)	
<u>Y</u> la	Men Men Marke Marke	2	MARCELIANE A. ALLI					ROSA J				
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty					and Number or R				
ő, L	1 and Heall Iem 2		ELLEN KING / DAUGE 20a. Method of Disposition		11321 Place of Dispos cemetery, crem			ARK PLAC	E CLI.		MD 20	J / 35 or Town, State
OL.	ages ant of nt: If it		XX Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	IOIII State	***			ı	20/2005			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinating the notified at 2008.		21. Signature of Fure al Service Licens	14.4				ERY 09/ S of Funera			ENTWOO	
ä	Depa Impo any ir		J. T. Mar	skell				S FUNERA LAND ROA			MD 2	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deather								Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	ATHEROSCLE	ROTIC C	ARD	IOVAS	CULAR DI	SEASE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec								
		<u>_</u>	Sequentially list conditions, if any leading to immediate	Due to (or as a consec	mence off.							
	nted I Insit	mine	Cause (Disease or injury	220 (0) (0) 22 2 00/1000	1401100 01).							
o,	exection and and rial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
8760,	cate be executed physician and the burial-transit	ical		d								
Ö	artifica ing ph e as th	Physician/Medical	IF FEMALE:			-						
Box	death certific e attending p id for use as t	ian/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	al death 3		pregnancy			1	23d. Date of o	delivery Day Year
0		ysic	1 ☐ Yes XXXNo 9 ☐ Unknown	4□Pregnant at time of c 9□ Unknown	leath 5 □	Other (specify)				WOUNT	Day
<u>α</u>	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying	cause give	en in Part I.	23e. Did	tobacco u	rse contribute	to the cause of death?
Records,	puires n sign ald be	d by	CARDIOVASCULAR AC	CCIDENT					1 🗆	Yes 2	□No 3□	Probably XXUnknown
CO	s been s s been s s should	olete	DIABETES						24a. Wa	an	24b. Were	autopsy findings available
R	0 5 0	Completed	RENAL FAILURE						auto perf 1 Yes	ormed?	prior t death	
Vital		BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			03 20110
of V	Physician: this certific ral director,	2	1 □ Yes XX No		ER/Outpatien	t 3⊡ [OOA Oth	er:X4X Nursing I	Home 5 ☐ Res	idence	6 □Other (S _p	pecify)
n c		ion:	27. Manner of Death XX Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Worl	y at k?	28d. Describe	how injur	y occurred	
isio	r Attending er death. rector: Atter by the fune:	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm str	M fact		Yes 2 □ No	29f Location	/Stroot as	d Number or	Rural Route Number,
Division		ertif	4 ☐ Homicide determined	building, etc. (Special	fy)	set, facto	ny, onice		City or To			nurai noute reuniber,
	Hospital 14 hours a Funerel I	aic	29a. Certifier XX Certifying Phy	sicien: To the best of my know	owledge, death	occure	d at the tim	ne, date and place	e, and due to the	cause(s)	and manner	as stated.
		edicai	(Check only 2 Medical Exami one)	ner: On the basis of examina and manner stated.	ation and/or inv	estigation	on, in my o	pinion, death occ	urred at the time	, date and	l place, and d	ue to the cause(s)
	To the within To the	ž	29b. Signature and title of certifier			2	9c. License	e number		29d. Dat	e signed (Mo	nth, Day, Year)
)			bough				DO	053782		SEPT	TEMBER	28, 2005
	(7)		30. Name and address of person who co			,						
		•	SURESH VERGHESE 31. Date filed (Month, Day, Year)	An Conjetencia Ciana	th and		11701	LIVINGS	TON RD.	#101	FT. V	VASHINGTON, MD
	Sta Registr		OCT 0 3 2005	Stantas A	Good							

			State of Maryland / Department	artment of Health and I rtificate of Death	_	giene 005	5 33477
	5.		Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
	Physicia /Medic		Debebe Tujo		Septemb	er 28, 20	005 1:15 a ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ח	4c. County of	Death
			Washington Adventist Hosiptal	Takoma Park	1	Montgo	
	Funeral Director		5. Social Security Number 578.80.3725 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da March]	th y, Year) 1950 I	D. Birthplace (State or Foreign Country) Ethiopia, Africa
pue	A 11		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation			10d. Inside City Limits
Mac	al', or itams 23a or 28a-1 show Exeminer must be mulified al	ţ	Maryland Montgomery Rockville	2			1 ☐ Yes 2 ☒ No
the	or 28a-f	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of Wha	at Country?
, w	23a o	ai D	2313 McAuliffe Drive	20851		U.S.A.	
dea	Itams Ingr.ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No	- 14. Race -	American Indian, White, etc.
9 4	n o u	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No Specify:		Sacaifu	
	"natural", or		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation			Black
2 2	edic ledic	Completed	(Specify only highest grade completed) (Give	dent's Osdal Occupation kind of work done during most of wor DO NOT use retired)	rking	16b. Kind of Busir	1855/Industry
with a	thar than	mo	Elementary/Secondary (0-12) College (1-4or 5+) 2 Manaş	· ·		Public/	Parking
و ا	ital Hygiene. Id other then "natu avant, Ita Medica	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle	, Maiden Surname)	
4	Menta urked utic a	To	Tujo Welani	Meaza Gl	hebre -	Ghiorgis	
Cally call a filed within 72 hours after death with the Marvland	and Is me			ng Address (Street and Number or Ru		•	
, ,	health m 27 her tr			McAuliffe Dr. Ro			
Pages	Department of Health and Mental Hygiene Important: If item 27 Is marked other than any injury or other traumatic avant, Item once.	1	I A burial 2 U Cremation 3 U Removal from State	matory or other place)	Date	20c. Location - Cit	
	niury niury	ľ		Heaven Cemet. 10/0 Name and Address of Facility H			Spring, MD
3 8	Depa Impo any i		Narry A. Lecentre 11	1800 New Hampshire	e Ave. S	ilver Spr	•
	hysician /Medical xaminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure ist only one cause on each line. Immediate Cau Final disease or condition resulting in death) a	almie Ocloccal Infe	lills	rrest,	Approximate Interval Between Onset and Death
The law requires that the death certificate he executed	physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diagonal Last resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	heiat len	L		
the death cedif	ed by the attending p detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date o Month	
ruo, r	n signed k	ρλ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did t	. /	ute to the cause of death?
	as been s 2 should	piet	Sehtal leepiteelle	ris in	24a. Was		re autopsy findings available
That	is certificate has director, page 2	Completed	97-00		autor perfo 1 ☐ Yes	rmed? dea	or to completion of cause of uth?] Yes = 2 □ No
	artifică ctor, I	Be	25. Was case referred to medical examiner?	26. Place of Dea	ath Check only o		
hveir	S in	To I	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing H	lome 5 Resi	dence 6 Other	(Specify)
2 00	After t unera	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe l	now injury occurred	
מיל לי	tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be 38e Place of Injury. At home farm str	M 1 Yes 2 No			
	s after o	Certification;	4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, stream of building, etc. (Specity)	eet, factory, office	City or Tox	Street and Number ovn, State)	or Rural Route Number,
DIVISION OF VICE	within 24 hours after death. To tha Funeral Director: After the completely filled in by the funeral	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	er as stated. If due to the cause(s)
To the	withir To th comp	Me	29b. Signature and title of certifier	29c. License number	1	29d. Date signed (A	Month, Day, Year)
	(56/	471	9/10	1/OV
	7		30. Name and address of person who completed cause of death (Item 23a) (Type,	1.1	1	17	MD 20912
		Ļ	Nasereen Kango, H.D., 71	000 Corroll Av	re, # 3	205, Ta	Koma Pork
	Sta Registi		31. Date filed (Month, Day, Year) CCT 0 3 2005 Registrar's Signature	Mes .	•	,	

			For State Registrar		State 0	i wai ya	Cei	artment of I rtificate of	Death	i wichtai m	Reg. No.	005	33478
	[®] Physici		1. Decedent's Name Edna	(First, Middle, La Cather		Thomas				2. Date of D Septem	eath ber ^{Day}	7 2005	3. Time of Death 5:25P M
	/Medic Examin		4a. Facility Name (If	_		mber)			or Location of De		4c.	County of Death	
-	Funeral		5. Social Security Nu		Sex	7. Age (In yr	s. last birthday)	If Under 1 Year		rs. 8. Date of B		Carroll 9. Birth	nplace (State or Foreign
	Director		222-10-30	21	1□ M 2 Ö F		87 Yrs.	Months Days	Hours M	s. Date of B (Month, D)	3, 191	7 Mai	ryland
	yland now		Usual Residence of I	10b. County		10c. (City, Town or Lo	ocation					10d. Inside City Limits
	Be-fal	Director	MD	Carrol	1		Tane	ytown					Yes 2 ☐ No
	h with ti	al Dire	10e. Street and Num 100 An	trim Blv	/d.			10f. Zip Code 217	87			zen of What Cou	untry?
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f ahow amy injury or other traumatic avent, the Medical Enait and must be a cilified at ance.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	_	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 X No ve		Was Decedent of ff Yes, specify Cut	oan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		14. Race - Amer Black, White Specify: W	rican fndian, o, etc. hite
5	72 hour			15. Decedent's E	ducation		16a. Dece	dent's Usual Occu	pation	unstina	16b. Kir	nd of Business/Ir	
171	within 7 iene.	Completed	Elementary/Secon	, , ,	College (kind of work done DO NOT use retire nemaker	a during most or v ad)	vorking	0,	wn home	
70	be filed ntal Hyg ed other avent,	Be	17. Father's Name (F		t)					lame (First, Middle			
ar yie	should nd Mer n marke nmaric	2	19a. Informant's Nar		(Type, Print)		19b. Mailir	ng Address (Stree		Rural Route Numi	ber, City or	Town, State, Zi	ip Code)
, M	and 2 ealth a m 27 ls		Joseph D		s - son	- Inches	109	Saddleto		Taneytowr	n, MD	21787	
Dallinore	Pages 1 tment of H tant: If itel		° 4 □Donation	Cremation 32 5 Other (Speci	fy)	State	cemetery, crer	osition (Name of matory or other pla Cremator		Date UNI	100	er, DE	Town, State
מ	permit Depar Impor any in		21. Signature of Fun	eral Service Lice				2. Name and Addr TOKらで見てい		, 615 BA	HALLA	ed, Dove	R, DE
	Physician		Immediate Cause (F	t failure. List only	one cause on e	caused the de	ath. Do not ent	ter the mode of dy	ing, such as card	iac or respiratory	arrest,		Approximate Interval Between
	/Medical		disease or condition resulting in death)		a. Due to	(or as a cons	equence of):	mlar a	reach	int			Onset and Death 24hr
	/Medical Examiner	er	resulting in death) Sequentially list con- if any, leading to im-	ditions,	arti	(or as a consi	elin	tu V	asenlo	int v Ose	rase		
,00,	/Medical Examiner	Ical Examiner		ditions, mediate lying nfury	Due to	rins	equence of):	the V	reach	int Wase	rnse		
,00/00	/Medical Examiner bhysician and streep be executed bhysician and streep briat-transit	edical	resulting in death) Sequentially list con if any, leading to imreause. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions, mediate lying njury ast	c. Due to	(or as a conse	equence of):	the V	asent	int Wase			24his 24his 20jis 87ijis
,00,	/Medical Examiner bhysician and streep be executed bhysician and streep briat-transit	edical	resulting in death) Sequentially list con if any, leading to imreause. Enter Under Cause (Disease or it that initiated events resulting in death) Li	ditions, mediate lying hiury ast	b. Due to c. Due to d	(or as a consi	equence of): equence of): equence of):	the Vage		int Wase		3d. Date of deliv	24his 24his 20jis 87ijis
F.O. BOX 66/60,	/Medical Examiner bhysician and streep be executed bhysician and streep briat-transit	by Physician/Medical	resulting in death) Sequentially list con if any, leading to imrouse. Enter Under Cause (Disease or inthat initiated events resulting in death) Laft FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2	ditions, mediate lying lying niury ast	Due to Due to Due to Due to Due to	(or as a consideration of pregointh 2 Feath at time of own	equence of): containing the sequence of the s	Ectopic pregnance	:y	23e. Did	tobacco us	3d. Date of delive Month	Onset and Death 24hin 20yrs 87yun
necords, F.O. Box 66/60,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	resulting in death) Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or inthat initiated events resulting in death) Li If FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2	ditions, mediate lying lying niury ast	Due to Due to Due to Due to Due to	(or as a consideration of pregointh 2 Feath at time of own	equence of): containing the sequence of the s	Ectopic pregnance	:y	23e. Did	tobacco us Yes 2 s	3d. Date of delive Month se contribute to the No 3 Profession 24b. Were auto	Onset and Death Office Organ 87 Year The cause of death? bably 4 Unknown opsy findings available ompletion of cause of
vital necords, P.O. Box 66/60,	The law requires that the death certificate be executed as the law requires that has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	resulting in death) Sequentially list con if any, leading to imrouse. Enter Under Cause (Disease or inthat initiated events resulting in death) Life FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 y 1 Unknown Part fl. Other significations.	ditions, mediate lying niury ast pregnant months?	Due to C. Due to Due to Due to Due to Due to Due to	(or as a consi	equence of): equence of): inancy tal death 3[death 5[esculting in the units of the seculting	Ectopic pregnance Other (specify)	ven in Part I. 26. Place of D	23e. Did 1	tobacco us Yes 2 s an ppsy ormed? 2 No one)	3d. Date of delive Month se contribute to the second of t	Onset and Death Office Offic
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State of Maryland / Department of Health and Mental Hygien 2005	33	2 4 3
Contilients of Donth		

	A.		For State Registrar	State of Marylar	nd / Depa	artment of Hertificate of D	ealth and M Death		gien 2 () () 5 leg. No.	33479
•	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day Year	3. Time of Death
3	/Medic		Yolanda Ann	Thomas				Septem		005 7:16X
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or L			4c. County of Dea	
			Prince Georges 5. Social Security Number 6. Se		last hirthday)	Cheve If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Prince	Georges
160	, Funeral Director			☐M 2⊠F 4		Months Days	Hours Min.	8. Date of Birth (Month, Day July 2	(9, 1959)	Wash.,DC
	and		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary Inet	to	Md. P.G.	C	apito	1 Height	S			1x Yes 2□No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	death with the Maryland ime 23a or 28a-f ehow r man be notified at	Funeral Director	6845 Walker Mi	ll Road		20743			United S	tates
	оше	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
õ	or the	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specific	
Š	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	160 David	death Havet Convert	ion		BI	ack
21215-0036	within 72 hours after ene. then "natural", or ite ne Medical Exercite	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	iring most of work	ing	16b. Kind of Business	rindustry
7	withii ene. then	фщо	Elementary/Secondary (0-12)	College (1-4or 5+)		bilition	Techni	cian	Govern	ment
	be filed within 72 hours after death with the Marylan deathly glene. I all hygiene. I other then "natural", or iteme 23a or 28a-f show other then "asterile Executer count be notified at event, the Moulcal Executer count be notified at	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Name	e (First, Middle,	Maiden Sumame)	
ä		To B	Lionel J. Thoma	as Sr.			Cather	ine Di	xon	
Maryland	and and and and and ann		19a. Informant's Name/Relationship (7) Lionel J. Thom		19b. Maili	404 Balm	ore Dri	al Route Numbe	r, City or Town, State, .	Zip Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	1.00	2846 Date	20c. Location - City or	Town, State
Baltimore,	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3 🗆	Removal from State	cemetery, crea	matory or other place		/22/05		
Ħ	it. Partant		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		76.	LE CLEMA 2. Name and Address			Riverdal & Edward	
Ba	permit. Pages: Department of h Important: If ite eny injury or of		Marita En	"unuals)	/			_		,Md.20746
	200		23a. Part1. Enter the disease, or comp	lications that caused the dea						Approximate Interval Between
	Physician and Medical Examiner pruggistion and	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. FATAL CADue to (or as a conse b. TERM I NAL Due to (or as a conse c. Due to (or as a conse	quence of):	ARRHY ACH CAN	THMIA			Onset and Death
.O. Box 68760,	Attending Physician: The law requires that the death certificate be redeath. cloath. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	tal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	s that	oy P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b							1 U Y	'es 2□No 3□P	robably 4 MUnknown
Division of Vital Records,	The law re ite has be bage 2 shi	Completed							an 24b. Were at prior to death?	utopsy findings available completion of cause of
<u>ta</u>	ian: rtifica ctor, j	BeC	25. Was case referred to medical examiner?				26. Place of Deat			
<u>~</u>	hysic his ce I dire	To	1 ☐ Yes 2X No		ER/Outpatie	nt 3 DOA Other	r: 4 Nursing Ho	me 5 Resid	lence 6 Other (Spe	icify)
o uoi	nding PI ath. r: After the funeral	atlon:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work'	at ? es 2 \(\text{No} \)	28d. Describe h	low injury occurred	
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or R in, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dirticompletely filled in the	edical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exam	ysician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time vestigation, in my opi	e, date and place, inion, death occur	and due to the or red at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	-		29c. License	number		29d. Date signed (Mon	th, Day, Year)
			I A	TO		D58	1957		9-22-	05
R	(5)		30. Name and address person who do	completed cause of death (Ite	om 23a) (Typo,	Print) DRIVE	CHEVE	RLY N	9- 22- 1D 20785	
4	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature	-0	0,.00	- /	/	
	Regist		OCT 0 3 2005	Alaba A	Appa	Les of the second				

			For State Registrar	State of	Maryland / [artment <i>tificate</i>			and M		giene Reg. No .	005	33480
	Dhomini		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al	MICHAEL D. THOM								OCTOBE		2005	2:50 PM
4	Examin	er	4a. Fecility Name (If not institution, g				4b. City, To			t Death			County of Death	
			ANNE ARUNDEL ME 5. Social Security Number 6	. Sex 7	TER . Age (In yrs. last bir	thday)	ANNAP If Under 1		S If Under :	24 Hrs.	8. Date of Bir	th	IE ARUND 9. Birth	PEL place (State or Foreign ntry)
	Funeral Director		220 56 3237	1□ M 2□ F		Yrs.	Months	Days	Hours	Min.	JUNE 1	y, Year) 9 , 195		INGION D.C.
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		nation							10d. Inside City Limits
	show ed at	ō					cation							1 ☐ Yes 2X No
	the N	Director	MARYLAND ANNE AR 10e. Street and Number	UNDEL	CROFTO	N	10f. Zip C	ode				10g. Citiz	en of What Cou	ntry?
	3a or	0	1138 JEFFERY DRI	VF:			211	14				TINTT	ED STAT	T.S
	death	Funeral	11. Marital Status		ent Ever in U.S.	13.		nt of His	spanic Orig	gin? (Spe	cify Yes or No		4. Race - Ameri Black, White,	can Indian,
98	or Ite		1 Never Married 2 Marrie	d 1 ☐ Yes 2 If Yes, Give	□¼ √∘		1 🗆 Yes 2[Specify:	, , , , , , ,	,		Specify: WHI	
215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show Its Mydigal Examiner, ust be notified at	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or Dat			ient's Usual		tion		-		nd of Business/Ir	
7.	nin 72 n "na Madic	plet	(Specify only highest Elementary/Secondary (0-12)			(Give	kind of work DO NOT use	done di	uring most	t of worki	ng			
212	d with giane. er ther	Completed	12	0		ARP	ENTER					CON	STRUCTI	ON
	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "natural", or Items 23a or 28a-1 show marked other then "natural", or Items 23a or 28a-1 show marke event, the Modical Examiner routine be notified at	Be (17. Father's Name (First, Middle, La	ast)				i	18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)	
<u> </u>	2 should be fi and Mental H is marked ot reumatic ever	ို	EDWARD DALTON TH		106	A A million	a Address (Ctront			AMELIA			n Codel
Maryland	S 8 9	1	19a. Informant's Name/Relationshi				940 76						Town, State, Zij	<i>code)</i>
<u>ē</u>	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic 0006.		BROOKE L. THOMPS 20a. Method of Disposition	•	20b. Place of	f Dispo	MTLLS sition (Name natory or oth	of			ate		20715 cation - City or T	own, State
altimore,	Pages nent of I int: If it		1 ☐ Burial 2√Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		ate	-	EMATOR		"	10-	11-05	EDGE	WATER, M	D
alti	permit. Pag Department Important: I any injury o		21. Signature of Aupéral Service Li	censee					s of Facilit	GEOR	GE P. I		FUNERA	
8	82589		1000c								D ROAD		EWATER,	MD. 21037
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can nly one cause on ea	used the death. Do	5		_			r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			ng	_a	vice	V				Comos.
	Examiner			Due to (o	ras a consequence	of):								
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	b Due to (o	r as a consequence	of):								
	cuted nd ransit	Examiner	ulat lilitiated events	c										
00	cate be executed by sician and the burial-transit	EX	resulting in death) Last	Due to (o	r as a consequence	of):								
8760	physic physic the b	dlcal	·	d								-		
Box 6	eath certifica attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy							2	3d. Date of deliv	rery
	death e atter d for u	iciar	in the past 12 months?	4□Pregna	th 2 Fetal death nt at time of death]Ectopic pred] Other (s <i>pe</i> d						Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown	9□Unknov										
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition	is contributing to dea	th but not resulting i	n the u	nderlying cau	ıse give	n in Part I.		23e. Did t	, -	se contribute to t No 3 ☐ Pro	the cause of death? bably 4 \(\sum \text{Unknown}\)
Records,	requi	Completed										•		
Rec	ne law has b	ldm									24a. Was auto perfo	psy ormad?	prior to co death?	opsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical						26 Place	of Death	1 Yes	2 No	1 🗆 Yes	2 □ No
>	Physicien: this certificant director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1	patient 2□ER/Ou	utpatier	nt 3 DOA	Othe					☐Other (Speci	fy)
n of	ng Ph Iter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of	Injury 28b.	Time o	f 28	c. Injury Work	at ?	:	28d. Describe	how injury	occurred	
siol	Attending r death. ector: Afte by the fune	catle	2 Accident investigation in Suicide 6 Could no	ation			M		/es 2 □					
Division	or Ati	Certification;	4 Homicide determin	ned 28e. Place of building	of Injury - At home, fa g, etc. <i>(Specify)</i>	arm, sti	eet, factory,	office		1	28f. Location (City or To			al Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying	Physician: To the t	pest of my knowledge	e, deat	h occurred at	the tim	e, date an	d place,	and due to the	cause(s)	and manner as s	stated.
	To the Hospital within 24 hours of To the Funeral completely filled	edical		xaminer: On the bas and manne	sis of examination ar									
	To the To To To To To To To To To To To To To	Ň	29b. Signature and title of certifier	1,50 c			29c.	License	number			29d. Date	signed (Month.	Day, Year)
	10		1. All	neces	10	_	(11	183	8		101	81200	ン
_	4		Stuart E.	ho completed cause	ick, mo)	90	0	Bes	tga.	He Ru	· 6)пиаро	lis, md.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 4	2005	gistrar's Signature	19	me!							

			Plea	State of Mo						ible.	
			For State	State of Ma	aryland / Dep	partment of the strate of the			- 61	005	3348
	18 18 18 18 18 18 18 18 18 18 18 18 18 1	3	Registrar 1. Decedent's Name (First, Middle)	e, Last)		ortinoate or	Death	2. Date of Dea	Reg. No.		3. Time of Death
1.	Physici		FRANCIS ELW		CON			Month	Day	Year	M
	/Medic Examir		4a. Facility Name (If not institution		SUN	4b. City Town	or Location of Deat	10	09 4c. Count	05 v of Death	2:21 a ^m
	Exami	er	CIVISTA MEDIC			LaPlata				harles	
*	Funeral	-	5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.		h		ace (State or Foreign ry)
	Director		217-70-6122	1⊠M 2□F	49 Yrs.	Months Days	Hours Min.	(Month, Day	y, <i>year)</i> 1956	MARY	
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or						
	show	5		RLES	LA PLA					10	d. Inside City Limits 1 ☐ Yes 2/C/No
	the Marylar r 28a-f show	Director	10e. Street and Number		DA 1 DA						
1	a or 3	늅	5650 HILLTOP	DOVD		10f. Zip Code 20646	5		10g. Citizen of		ry?
(death with the Maryland ms 23a or 28a-f show truat Le nulling at	Funerai	11. Marital Status	12. Was Decedent E	Ever in U.S. 113			necify Ves or No.	U.S.	ce - America	n Indian
3		F.	1 Never Married 2 Mar	Armed Forces?	10	3. Was Decedent of I If Yes, specify Cub		o Rican, etc.)	Bla	ick, White, e	
) 	hours after urei', or ite	þ	3 ☐ Widowed 4 ☑ Divorced	If Vac Give		1 ☐ Yes 2 No	Specify:		Specif	r. WHI	ГE
21215-0036	72 ho	Completed	15. Deceden	t's Education st grade completed)	16a. Dec	edent's Usual Occup	pation	4-1	16b. Kind of B	lusiness/Indi	ustry
21	E . E .	pje	Elementary/Secondary (0-12)	College (1-4or 5	+) life	ve kind of work done . DO NOT use retire	d) diring most of wor	King			
27	77 72 12 12	S	12		SER	VICE REP	RESENTA	ATIVE	BELL	ATLA	NTIC
פי	od ta b ≥	Be	17. Father's Name (First, Middle,					ne (First, Middle,		me)	
$\frac{1}{\sqrt{3}}$	should be and Mental marked o	၉	JAMES BUDDY			-	MARY IN				
Maryland	2 4 7	İ	19a. Informant's Name/Relations MILDRED G. BO			iling Address (Street					
	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dis	O HILLTO		Date PLA	20c. Location		
Baltimore,	8° = ₽		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from State	cemetery, cr	ematory or other pla				•	
達	. 5 2 3		21. Signature of Euneral Service	Licensee MO(NITY ME	MORIAL (22. Name and Addre		14-05	WALDO	RF,MA	ARYLAND
Ba	Depenting Depending Single Sin		Mich	001		RAYMOND	FUNERAL	SERVI	CE,P.A		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do not e	LA PLATA	MARYI ng, such as cardiac	AND 20 or respiratory ar	646 rest,		Approximate
	Physician		Immediate Cause (Final	only one cause on each lin	10.		0 11 1				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	12	John	2			
	Examiner		0	, aas	ngren	e of	eet				
	T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dye to (or as a	a consequence of):	2					
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ath	eras	cu	w				
760,	te be executed ysician and e burial-transit	Ω :	resulting in death) cast	Due to (or as a	a consequence of):		Mela	_			
687	e ys	dicai		d		3 74 .00					
9 x	leath certificate attending phy: I for use as the	/Me	IF FEMALE:	23c. If yes, outcome	of prognance						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnancy	/			ate of delivery onth D	∕ Day Year
o.	requires that the death certifica een signed by the attending ph hould be detached for use as th	Physician/Med	1 Yes 2 No	9□ Unknown	ume or deau	Citier (specify)					
Δ.	res that igned b be deta	by Pi	Part II. Other significant condition	ns contributing to death bu	it not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use cont	tribute to the	cause of death?
rds	quires n sign	p p	Renal for	ellere,	Super	liner	~ 。	1 🗆 Y	es 2 □ No	3 Probab	bly 4 dUnknown
Vital Records,	aw requires s been si s should b	Completed	mutment	Dialumi	, anon	rei, z	entrape	24a. Was a	an 24b.	Were autops	sy findings available
R	The law ate has b page 2 st	E O	I sugar ch dut	relema	. 5 10 B. A	into &	3 11 1	autop: perfor	med?	prior to com: death? 1 Yes 2	pletion of cause of
ital	ician: The certificate ector, pag	BeC	25. Was case referred to medica.				26. Place of Dea	th (Check only or		10 105 2	- No
>	S S =	To	exa <i>m</i> iner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗷 Inpatier	nt 2 ER/Outpati	ent 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	ence 6 Oth	ner (Specify)	
n o	rng fter inei		27. Manner of Death 1 □ Natural 5 □ Pendin	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury		y at k?	28d. Describe h	ow injury occur	red	
SiO.	Attending r death. sctor: After by the funer	cati	2 Accident investig	gation			Yes 2 □ No				
Division of	or At fiter of Direct in by	Certification:	4 Homicide determ		ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	oer or Rural I	Route Number,
ų.	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ö	29a. Certifier 1 Certifyin	Physician, To the best	d - de sudadas da		1.				
	24 ho Fun etely	edical	(Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or	ath occurred at the tile investigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, c	ause(s) and ma late and place,	anner as stat and due to ti	led. he cause(s)
	of this of the omple	Me	29b. Signature and title of certifie	1		29c. Licens	e number	2	29d. Date signe	d (Month, Da	ay, Year)
	- > PP 0		- Janes	De Lette	Thun	D- 0	008370	1	gat	9 2	005
	1		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type		000370				
	4		Pritchett, Paul				1317 LaP	ata Md	2067.6		
***	Sta		31. Date filed (Month, Day, Year)	32. Begistra	r's Signature	Cont.	-JI/ Lar.	ata PU.	- 20040 -		
	Registr	ar	OCT 1	4 (UU) / Posts	and Il. ha	100 ALL					

		1	1 - For State Registrar	State	of Marylai		rtment of F	lealth and N Death		jiene 0 0	5 3348	82
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	th	3. Time of De	eath
	Physicia /Medic		DORSEY	Ε.	TYLER				Month SEPT.	2, 200	(ear)5 4:12	РМ
	Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. County of		
			PRINCE GEORGE	'S HOSPTI	AL CENT	rer	(CHEVERLY		PRIN	NCE GEORGE	S
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or F Country)	
	Director		579-76-4435	ty⊡M 2□F	43	3 Yrs.	Months Days	Hours Min.	(Month, Day March 6	1962	Washingto	n,DC
7			Usual Residence of Decedent									
2	a ho	_	10a. State 10b. County		_	ity, Town or Lo					10d. Inside City	
Ž	Ba-f	Director		ce George	e's		Land	over			1 ☐ X es 2	NO
÷.	or 2	Dire	10e. Street and Number				10f. Zip Code		1	log. Citizen of Wh	nat Country?	
5	238	-a	7311 Sheriff					20785			d States	
9	tems mer	Funeral	11. Marital Status	Armed F		U.S. 13. V	Vas Decedent of I Yes, specify Cub	fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.	
	, E	by Fi	1X Never Married 2 ☐ Marr	If Yes, G	21∑ No ive	,	☐ Yes 21 No	Specify:		Specify:	Black	
	e a		3 Widowed 4 Divorced		Dates:	160 David	ent's Usual Occur			405 165 4 - 4 5		
3 2	ed a	lete	15. Deceden (Specify only highe)	(Give		during most of work	ring	16b. Kind of Busi	ness/industry	
1 3	than 9	Completed	Elementary/Secondary (0-12) $11 { m th}$	College	(1-4or 5+)		Labor	•		Priva	ate	
א ק	Hygi ther	ပိ	17. Father's Name (First, Middle,	Last)			Дарог	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
at y fall u K I K I J-0000 should be filed within 79 hours after death with the Manyland	antal d	80	William Maka	1					ria Thom			
y	mari mati	ပို	19a. Informant's Name/Relations			19b. Mailin	a Address (Street	and Number or Rur			tate Zin Code)	
	ith ar 27 is trau		Gloria White				Sheriff		Landover		20785	
ב ב	Hea tem othe		20a. Method of Disposition	<u> </u>	20b.	Place of Dispo-	sition (Name of			-	ity or Town, State	
	y or fi		1 ☐ Burial 22☐©remation 1 ☐ Quantition 5 ☐ Other (S			-	natory or other pla	- 1 - <u>-</u>	10-05	Rolter	ville, Md.	
	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. The Medical Evaninar must be rediffied at once.		21. Singeture of Funeral Service		1) 1	-	ake Crema . Name and Addre					
	Depa Impo any Ir		Haron	Mason	. Jal	1.		land Ave.	apitol 1	Mortuary	, Inc. 20002	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea						Approximate Interval Betwe	000
p	nysician		Immediate Cause (Final disease or condition		NSHOT W	(/	2) OF TO				Onset and Dea	ath
	/Medical		resulting in death)	_ a	(or as a conse		2) 0: 10	KOO				
E	xaminer		One and the Box of the second	b								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conse	quence oi).						
of the	nd	Examiner	that initiated events	с								
5 9	ian a rial-1	Ä	resulting in death) Last	Due to	(or as a conse	quence of):						
or ou,	physician and the burial-transit	dicai		d								
		Med	IF FEMALE:									
	tend or use	an/l	23b. Was decedent pregnant in the past 12 months?		utcome of pregr birth 2 ☐ Fet		Ectopic pregnanc	/		23d. Date Month		
	the al	sici	1 Yes 2 No	4□Preg 9□Unki	nant at time of	death 5□	Other (specify) _			None	n Day Yea	21
, E	d by letach	Physician/Me			da 186 6 . A 224				00- Dida-			
The law contines that the death contin	been signed by the attending should be detached for use as	by	Part II. Other significant condition	ons contributing to	Jean Dut not re	isulang in the ur	idenying cause giv	en in Paπ i.			ute to the cause of dea	
	been si	ted							101	es 2.⊡&No 3 	Probably 4 Uni	mown
ב נ	has b	ple							24a. Was a autops	sy pri	ere autopsy findings ava or to completion of caus	ailable se of
<u> </u>	page	Completed							perform 1 🔀 Yes		ath? XYes 2□No	
110	certificate rector, pag	Be	25. Was case referred to medica examiner?					26. Place of Deat	h (Check only or	ne)		
Or VIII	this c al dire	္ရ	1X Yes 2 □ No			XER/Outpatien		4 Nursing no		ence 6 Other		
֝֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	in a final	on:	27. Manner of Death 1 □Natural 5 □ Pendir	9 0 0	nth, Day Year)	28b. Time of Injury	28c. Injui	k?		ow injury occurred		
מוני	leath tor: /	cat	2 Accident investi 3 Suicide 6 Could	not be		15:14		Yes 2⊠No		BJECT SHO		
	after of Direction by	Certification;	4X Homicide determ	lined 286. Plac	e of Injury - At I ding, etc. (Spec	eify)	eet, factory, office		15 14 V T	treet and Number n_State T.AGE_GRI	or Rural Route Numbe EEN DRIVE	r,
1 70000	ours sours sours sours sours sours sours sours source to the source to t		29a. Certifier 1 ☐ Certifyir	ng Physician: To th	e best of my kn	LAWN	occurred at the ti	me, date and place,	and due to the c		EK, MD.	
INISION A	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical one)	Examiner: On the	basis of examin nner stated.	nation and/or inv	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, an	d due to the cause(s)	
-	To t	Σ	29b. Signature and title of certifie	r		^	29c. Licens	e number	2	9d. Date signed (Month, Day, Year)	
	11		Tatruili	nonice	-tall	berr		O.C.M.E.		SEPT.	3, 2005	
			30 Name and address of person	who completed car	of death (Ite		Print) PENN STR	ЕЕТ ВАГТ	IMORE, N	MD. 2120	<u> </u>	
	Sta	te	31. Date filed (Month, Day Year)	32.	Registrar's Sign	. 3		-HI DALI	TITORES I	2120	<u> </u>	
	Registr		UUT	1 4 2005	MARIA	rature /	goods					

Terry Takamori 05-06517 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland		artment o			lental Hy	giene	005	334	83
i	Physici	an	Decedent's Name (First, Middle	•		m - 1	•			2. Date of Dea Month Septemb		2005	3. Time of I	Death M
	/Medic	al	Terry 4a. Facility Name (If not institution	T.	er)	Tar	amori	n, or Location		peptellib		2005 ounty of Death	0610	
	Examin	er	Baltimore Washi			nter	,	Burnie				ne Arur	ide1	
	Funeral Director		5. Social Security Number 575–22–8498		Age (In yrs. Ia		If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birt (Month, Da Feb. 6	h v Year)	9. Birth	olece (State or	r Foreign
	p .		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation						10d. Inside City	v Limits
	aryla hov	5		Arunde1		dentor							1 ☐ Yes	
	28a-1	Director	MD Anne 10e. Street and Number	Arunder	0	dentoi	101. Zip Cod	е			10g. Citizer	n of What Cou	ntry?	
	3a or	<u></u>	535 Higgins D	cive			21	113				USA		
	deetl	Funerai	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Decedent	of Hispanic Or Juban, Mexical	igin? (Sp	ecify Yes or No- Rican, etc.)	- 14.	Race - Ameri Black, White,		
9	72 hours after deeth with the Maryland "natural", or items 23e or 28e-f ehow idical Exeminant be notified at	by Fu	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes 2 II Yes, Give	□ No		1 ☐ Yes 2 🔀						sian	
9500-61212		ed b	15. Deceden	Year or Date	s: 1947	16a. Dece	dent's Usual Oc	cupation			16b. Kind	of Business/In	dustry	
<u> </u>	within 72 ene. then "nai	piet	(Specify only higher Elementary/Secondary (0-12)		0(5+)	(Give life.	kind of work do DO NOT use re	ne during mos tired)	st of work	ing			,	
7	giene giene r the	Completed	12	Joinego (1 4	0.5.,	Maste	er Serge	eant			U.S.	Army		
ב	be filed tal Hygid of other event, I	Be	17. Father's Name (First, Middle, Sadaki Takamo)						ers Nami le Sa	e (First, Middle, -i.t-o	Maiden Su	ımame)		
Maryland	d Men narke natic	၉	19a. Informant's Name/Relations			10h Mailie	Address (Str			al Route Numbe	or City or T	our State 7	Code)	
<u>∞</u>	s 1 end 2 should if Heelth and Mer Item 27 ie marke other treumatic		Mae Takamori			1				nton, M	-		70000)	
ē,	s 1 er		20a. Method of Disposition		20b. Pl		sition (Name of matory or other			Date		tion - City or T	own, State	
Ē	mit. Peges pertment of h portant: if Ite y injury or of	1	1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (S		118		matory	1	9-30	-2005	Balti	more, N	1D	
Baltimore,	permit. Peg Depertment Important: eny injury conce.		21. Signature of Funeral Service	Licensee		22	Name and Ad	dress of Facili	ral	Home, P	. A .			
	40 2 6 d	1 11	23a. Part1. Enter the disease, or			Do not ont	12 Ridg	gely Av	enue	, Annap	olis,	MD 214	401 Approximate	
	Physician /Medical Examiner	Examiner	shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fram bearing to time adiate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or	h line.	JWP ence ol):							Interval Betw Onset and D	veen peath
/60,	ate be executed hysicien and he burial-transit	cal Exa	resulting in death) Last						iquence of):					
8	tificate ig phy as the			0.										
O. Box	at the death certifical by the ettending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2∏Fetal It at time of de	death 3[Ectopic pregna Other (specify				230	d. Date of deliv Month		'ear
Division of Vital Records, P.	as the	þ	Part II. Other significant condition	ons contributing to deat	th but not resu	ilting in the u	nderlying cause	given in Part	l. 	23e. Did to	L	contribute to t	he cause of de	
Ö	sw require s been si s should t	Completed								24a. Was		24b. Were auto	psy findings a	vailable
Ä	The laste has page 2	mo;								autop perfo 1 Yes	rmed?	death?	mpletion of ca 2□ No	use of
<u>E</u>		BeC	25. Was case referred to medica examiner?					26. Place	e of Deat	h (Check only o				
> >	Physic this ce al dire	2	1 XYes 2 □ No	Hospital: 1 🗆 Inp			nt 3□ DOA			me 5 🗆 Resid			у)	
בט	Attending Physicien: or death. ector: After this certific by the funeral director,	lon:	27. Manner of Death 1 □Natural 5 □ Pendir	g	Day Year)	28b. Time o	28c. I	njuryat Work? 1 ∐ Yes 2 🗷		28d. Describe !		occurred or STa		
ISI	or Attencation date death	ficat	2 Accident investi	not be 28e. Place of	Injury - At ho	me, farm, sti	M M reet, lactory, off			28l. Location (S				ber.
<u> </u>	5 P F 0	Certification:	4 Homicide determ	building	, etc. (Specify	•)	,,,		1	City or Tov	un State)			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi and manner	is of examinat	wledge, deat ion and/or in	h occurred at the vestigation, in re	e time, date as ny opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as s ace, and due t	tated. the cause(s)	
	To the within 2. To the complet	ž	29b. Signature and title of certifie	211	0		29c. Lic	ense number			29d. Date s	signed (Month,	Day, Year)	
)			30. Name and address of person	who completed caused	of death (Item	23a) (Type	Print)	OCME			Septe	mber, 2	4, 200	5
			Tasha 2 (iver where	6 Mu	D		Penn S	tree	t Balt	imore	, Maryl	and 21	201
	Sta		31. Date filed (Month, Day, Year)	32. Red	ar's Signat	ture								
	Regist	-	SEP 2	8 2005	Com .	J.	Sport	,						
DH	MH 17 Rev 1/2	001												

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 33484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Oct 7, 2005 **Physician Townshend** Fisher 7:30 pm Virginia /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Health Care Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Sep 6, 1910 Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F MD 577-38-1859 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th end Mental Hygiane. 7 is marked other than "natural", or frams 23a or 28a-1 shov traumatic event, the Medical Examinar must be notited at MD Frederick Frederick Funeral Director 1 ¥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 16th Street 21702 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: 2 Specify: white 3 Midowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales clerk store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Noble Fisher Isabelle Mariah Dodge Fisher 19a. Informant's Name/Relationship (Type, Print)
William Townshend 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 123 Stratford Village Way Bluffton SC 29909 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Scarpelli Funeral Home, PA 10/11/2005 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nam Scaffelli füneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien for use es the bune Physician/Medical Due to (or as a consequence of) tor: After this cartificate has been signed by the the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To \$ 140 1 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attandir within 24 hours aftar death.

To the Funeral Director: At complately filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/058 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe, M.D.; Woodsboro Med Cntr; P.O. Box 6; Woodsboro, MD 31. Date filed (Month, Day, Year) State OCT 1 4 2005 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year GLENN THRASHER OCTOBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City n/a THE JOHNS
5. Social Security Number HOSPITAL HOPKINS 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days 1**∑**M 2□F Hours W/W Yrs. Director 212-38-6269 68 Sep 24. Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-1 shov other traumstic event, the Medical Examinar must be notified at MD Allegany Cumberland 1√ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Pennsylvania Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 □ No IFYes, Give Year or Dates: 1955-57 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. sm 27 is marked other than "natural" or Itar 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Good Fellowship Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul L. Thrasher, Sr. Frances (Dyche) Thrasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Gene Thrasher brother 30 Pennsylvania Avenue Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ZBurial 2 Cremation 3 Removal from State = 5 Department or Important: If any injury or Sunset Memorial Park 10/11/2005 Cumberland 4 □ Donation 5 □ Other (Specify) MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature & Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fenock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** 3 DAYS /Medical Due to (or as a consequence of) **Examiner** I WEEK MASSIVE GI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit GASTRIC ULCER IMONTH Due to (or as a consequence of): Box 68760. the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has page 2 Division of Vital the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After s after dea... •al Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) 0 RES-OCC - mD CCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERICS WEISS

DHMH 17 Rev 1/200

State Registrar MD

4 2005

31. Date filed (Month, Day, Year)

PO BOX 110 TOWER 600 NORTH NOLFE STREET

BALTIMORE, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 7. 8 per fb g849 11-1-05 yt

				epartment of Health and I Certificate of Death		005 33486
	Physici	an	Decedent's Name (First, Middle, Last) Stoneburg Thouse		2. Date of Death Month	Day Year S'LISAM
	/Medic		Ethel Stansbury Thaye 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	10- 0	4c. County of Death
			537 National Highway	LaVale		Allegany
	Funeral Director		5. Social Security Number 212-24-2208 6. Sex 1 □ M 2 ♥ F 7. Age (In yrs. last birth 7. Age (In yrs. l	Months Dave Hours Min	8. Date of Birth (Month, Pay, Y	9. Birthplace (State or Foreign Country) PA
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Allegany Lav	or Location Vale		10d. Inside City Limits 1, ☐ Yes 2 ☐ No
	or 28a-	Funeral Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	eeth w	eral	537 National Highway 11. Marital Status 12. Was Decedent Ever in U.S.	21502 13. Was Decedent of Hispanic Origin? (S	necify Ves or No-	USA 14. Race - American Indian,
336	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Madical Everth actinuation in Milliad at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White, etc. Specify: white
215-0036	72 ho	eted	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of wor	rking	6b. Kind of Business/Industry
2121	within giene. r than	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	life. DO NOT use retired) Cator	U	niversity
	s should be filled withir and Mentel Hygiene. Is marked other than sumatic event, Ire Me	Be	17. Father's Name (First, Middle, Last) James S. Thayer		me (First, Middle, Ma Ethel Mulla	
Maryland	should be and Mentel marked o	2	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Ru		
	1 and 2 Health a tem 27 Is			3514 Brice Hollow Rd	Cumbe	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Disposition (Name of , crematory or other place) Memorial Park		Cumberland MD
Balt	permit. Depart Import any lnj		21. Signature of Funeral Service Licens	22. Name and Address of Facility Scarpelli Funeral Ho 108 Virginia Avenue		nd. MD 21502
16	Avenue.		23a. Party. Exter the disease, or complications that caused the death. Do no shock, of heart failure. List only one cause on each line. Immediate Cause (Final	ot enter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death) Due to (or as a consequence :	the money be	reide	2 mm
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	n.		
N.	d d ansit	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	<i>j.</i>		
	ficate be executed physician and s the burial-transit	ai Exa	resulting in death) Last Due to (or as a consequence of):		
68760,	g physias the	ledicai	d			
Вох	eath certifi attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 Dectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	that the de led by the a detached f	hysic	1 ☐ Yes 2ÆNo 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		,
	or pe	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
Seco	ie law requir has been s je 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
talF		0	25. Was case referred to medical	26 Place of Dec	performe 1 ☐ Yes 2 € ath Check on one	
ž Z	hysicie	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Other: 4 Nursing H		ce 6 □Other (Specify)
Division of Vital Records,	Attending Physicien: r death. sctor: After this certifice by the funeral director.	ation:	2 Accident investigation	me of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
<u>N</u>	tel or Attend s efter death el Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attending Physicien: within 24 hours elter death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
1	To t To tl	×	29b. Signature and title of certifier Shelleni hu	29c. License number	290	Date signed (Month, Day, Year)
	. ^		30. Name and address of person who completed cause of death (Item 23a) (T	29c. License number 1) 0007 50 (ype, Print)	~ 3	<i>y</i> - <i>w</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i> - <i>v</i>
	10		ADDITION OD 911 No.	fil sky Late	rie or :	1 21907
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Sparte		

		For State Registrar	State of	Marylan		artment of H	lealth and M Death		iene 0 0	5 33487
Physic		1. Decedent's Name (First, Middle,						2. Date of Deat Month	Day # 1	3. Time of Death
/Medi Examir		Fernando Piero 4a. Facility Name (If not institution,		ber)		4b. City, Town, or	Location of Death	501000	4c. County	2000
	**	Washington Coun				Hagers				ngton
Funeral Director		5. Social Security Number 579-26-2770	. Sex 7. 11X2 M 2□ F	. Age (In yrs. 80		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 9.	Year) 1924	9. Birthplace (State or Foreign Country) Washington D.C.
P .		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo			001. 9,	1324	
death with the Maryland ms 23s or 28s-f show Emist be notified at	ō	Maryland Washin	aton		edysvi					10d. Inside City Limits 1 X Yes 2 □ No
h the f	Funeral Director	10e. Street and Number	9.011	1,0	Caysvi	10f. Zip Code		1	Og. Citizen of V	Vhat Country?
ath wit 23a o	ra D	8 Taylor Drive				2175			USA	
ter dez	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced	ent Ever in U es? ! No WW I	l.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - American Indian, k, White, etc.
Baltimore, Maryland 21215-0036 sernit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or my clury or other traumatic event, tra Medical Exercines.	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Da	P943-19	1 945	1□Yes 2₩ No	Specify:		Specify	White
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within iene.	omp	Elementary/Secondary (0-12)	College (1-4	4or 5+)	Super)		Postal	Service
nd 2 be filed al Hyg al Hyg tothel	BeC	17. Father's Name (First, Middle, La	,		, oup o.		18. Mother's Name	(First, Middle, A		
ylai	2	Michele	Vercelli				Lugena		Bassani	
Mar od 2 sh lith and 27 is n		19a. Informant's Name/Relationship				ng Address <i>(Street a</i> O rth Main	St. Kee	a <i>l Route Number,</i> dysv ill e		
or head them of the of them of them of them of them of them of the of them of the of them of the of them of the of t		20a. Method of Disposition		1 /	Place of Dispo	sition (Name of natory or other place	1			City or Town, State
Page ment of		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	city)	ale	rt Lin	coln Ceme	tery Oct.			od,Ma r yland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahov any lury or other traumatic avant, to Medical Examination must be notified at one.		21. Signature of Funeral S					^{ss of Facility} Osbo cocheague			ome,P.A. port,MD 21795
544		23a. Part1. Enter the disease, or conshock, or hearthailure. List or	omplications that cau	used the deat ch line.	h. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. By	(/ J	quence of):					With
Examiner	L	Somewhalls for conditions	PAVE	urnon	VIA					46
po ii	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseq	juence of):					
sxecute	Examiner	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	juence of):					
8760, rate be executed hysicien and the burial-transit			d							
X 687 certificate ding physise as the	Physician/Medical	IF FEMALE:								
S and a standard of the standa	clan/	23b. Was decedent pregnant in the past 12 months?		ome of pregna th 2 □ Feta nt at time of o	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery hth Day Year
P.O. thet the ded by the detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow		Jean 32					
Vital Records, P.O. Box 68 lician: The law requires that the death certifical has been signed by the attending placetor, page 2 should be detached for use as I	þ	Part II. Dther significant condition	s contributing to dea	th but not res	culting in the u	nderlying cause give	en in Part I.		acco use conti s 2 □ No	ibute to the cause of death?
ecor law req	olete	CORUNARY ARTS	KY DISH	AP 15				24a. Was ar		Vere autopsy findings available
	Completed	CHEONIE METKUA	Accessors 1640 Proposite		4 011	LOREK		autopsy perfor	ed?	prior to completion of cause of leath? ☐ Yes 2☐ No
of Vita Physicien: this certific	Be	25. Was case referred to medical examiner?	Liannital.		(and the same	26. Place of Death		4	
Of OF Phys	7.	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatien		4 🗆 Nursing Ho	me 5 Reside		
Vision of Vision of Attending For death.	atlor	Natural 5 Pending 2 Accident investiga	C. T.	, Day Year)	Injury		<br Yes 2 □No		, ,	
Division of Vital Re Division of Vital Re Within 24 hours after death. To the Funarel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place o	f Injury - At h	ome, farm, str fy)	eet, factory, office		28f. Location (Str City or Town	eet and Number, State)	er or Rural Route Number,
lospital of thours a cunarel body filled i		29a. Certifying	Physician: To the b	est of my kno	wledge death	occurred at the tim	e date and place	and due to the ca	use(s) and ma	pper as stated
the Hosnin 24 h	Medical	(Check only 2 Medicat Ex	taminer: On the bas and manne	is of examina	ation and/or in	vestigation, in my op	pinion, death occurr	ed at the time, da	te and place, a	and due to the cause(s)
To the within To the comp	ž	29b. Signature and title of certifier				29c. License			_	(Month, Day, Year)
				MAD			0622	132	TET IET MEB	R 30, 2005
SH-5-1		O. Name and address of person	N-MD	of death (Iter	n 23a) (Type,	Print) DWV/OV	PR H	ELECTON	MP	SITUA
St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 3		nistrar's Signa	B. A	ale				

				artment of Health and Mental Hi	ygiene 005 33488
			Decedent's Name (First, Middle, Last)	2. Date of D Month	Death 3. Time of Death
	Physici /Medic		HEINRICH WEHNER	Sept.	30, 2005 Year 8:22 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			113 Eighth Street	Pocomoke City	Worcester
L	Funeral Diréctor		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-40-0541 73 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of 8 Months Days Hours Min. Aug •	9. Birthplace (State or Foreign Country) 16, 1932 Germany
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Mary Ff sh	ţō	MD Worcester Pocomoke	e Citv	1. X Yes 2 ☐ No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a c		113 Eighth Street	21851	USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
036	filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or items 23a or 28a-f show ent, the Medical Evandra must be codified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 🖾 No	1 ☐ Yes 2 🖾 No Specify:	Specify: white
2-0	natur	Completed		dent's Usuaf Occupation b kind of work done during most of working	16b. Kind of Business/Industry
7	Agn.	npi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
7	iled w tygiel her ti		6 Labo	18. Mother's Name (First, Middle	Construction
Maryland 21215-0036	uges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinating the retified at	To Be	Heinrich Wehner		Volgelman
Mary	12 sho h and l 7 is ma traums		7:	ng Address (Street and Number or Rural Route Num Eighth St., Pocomoke Cit	
	s 1 and f Healt item 2 other		20a. Method of Disposition 20b. Place of Dispo	The state of the s	20c. Location - City or Town, State
Ë	Page nent o int: If		Burial 2 Cremation 3 Hemovat from State	ist Cemetery 10/3/2005	Pocomoke City, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Fune e Service Licensee	2. Name and Address of Facility	
	40 = 8 d		23a. Part1. Enter the disease, or complications that caused the death. Do not ent	Holloway Melson Funeral 103 Linden Ave., Pocomok	
1			shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
	Pnysician /Medical-		disease or condition resulting in death)	nyonathy	5715
	Examiner		Due to (or as a consequence of):	/	50
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	use	120/13
	outed d ansit	Examiner	cause. Emei unueriying Cause (Disease or injury that initiated events c.		
Ó	an an arial-tr	Exe	resulting in death) Last Due to (or as a consequence of):		
8760,	ficate be executed physician and s the burial-transit	dicai	d		
9	ertific ding p	0	IF FEMALE:		
Вох	that the death certifined by the attending properties as	ian	A Drognost at time of death	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
Р. О.	the di y the iched	ysic	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	Journal (apacity)	
	Physician: The law requires that the death certific this certificate has been signed by the attending raid director, page 2 should be detached for use as	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Vital Records,	w require been sig should b	ed k		1总	Yes 2□No 3□Probably 4□Unknown
ဝင္	e faw requ has been je 2 shoul	Completed		24a. Wa	s an 24b. Were autopsy findings available opsy prior to completion of cause of
œ —	yslcian: The iis certificate ha director, page	Com			death?
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only	
	Physic this c	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		sidence 6 Other (Specify)
חכ	ding I	lo	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	how injury occurred
Division of	i or Attending after death. Director: After in by the fune	Ical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, str		(Street and Number or Rural Route Number,
<u>≥</u>	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only and	h occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	To the h within 24 To the F complete	Medical	and manner stated.		
	To To	-	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			mound with so, D.	- 11(0/1)	1-20-03
1	t. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Charles Staubs, D.O 101A Ma	urket St, Pocomoke, N	nd 21851
	Sta	te	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	1 net si, loculture, 1)	W. 010
	Registr	ar	OCT 0 3 2005 Keen & A	parki	AND COMPANY OF THE PROPERTY OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0.05For Steta Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mary Romona Wolford 6:30 PM CTOBER /Medical 7005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Hospital Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 95 **Director** West Virginia 15 1910 217-28-6255 Usuel Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov treumatic event. If a Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 11912 Robinwood Drive 21742 items 23e United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Be Completed by Specify: 3 X Widowed 4 ☐ Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Mary al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked o John Price Bertha Crawford Price Dollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tree once. Hubert E. Wolford, Jr. (Son) 22047 Mohawk Drive Smithsburg Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem Park 10-8-05 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Muslon Mule 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helm failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician miratery 707 /Medical Due to (or as a consequence of): Examiner ne um onia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical the ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify)

or Attending Physician: The law requires that the death certificate be executed Division of Vital funeral director, After after death. the in by

Ramona

Be Completed Certification; To Medical

1 Yes 2 No

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 | Homicide

(Check only one)

KHALID. HA.

31. Date filed (Month Car Year) 2005

27. Manner of Death

within 24 hours a To the Funeral C To the

State Registrar

29b. Signature and title of certifier 23/2

WASERM

5 Pending

investigation

6 Could not be determined

and manner stated.

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P52323

1 Yes 2 No

29d. Date signed (Month, Day, Year) 10/05 105

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1500 Pennsylvania Avenue

Hagerstown, MD 21742

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3□ DOA

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		-	For State Registrar	9	State of	Marylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a Death	ind Me	ental Hyg	iene	/ 11 11 15	331	+90
			Decedent's Name (First, M.	ddle, Last)								2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physicia /Medic		William Juni	or WAL	LS							October			1410	М
	Examin		4a. Fecility Name (If not institu							Location o	f Death			County of Death		
			11 W. Baltim						_	town If Under 2	24 Hrs.	O Data of Birdh		Washing		Carrier
	Funeral		5. Social Security Number 220–28–2764	6. Sex 1⊠ M	1 2 F	7. Age <i>(in yr</i> s. i 74	ast birtnday) Yrs.	Months	Days	Hours	Min	8. Date of Birth (Month, Day, March 28	Year)	9. Birti	iplace (State o intry) [arylan	r roreign A
	Director	-	Usual Residence of Decedent			74						Taren Zi	J 9 1	- J J + F	aryran	<u> </u>
	yland now		10a. State 10b. Cou	nty		10c. City	y, Town or Lo	cation							10d. Inside Cit	
	a-f sl	cto	Maryland Was	shingto	on	I	Hagers	town							1 🔀 Yes	2 No
	or 28	Oire	10e. Street and Number	-		"		10f. Zip				1	-	en of What Cou	untry?	
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	er de Items	Funeral Director	11, Marital Status 1 ☐ Never Married 2 ☑ !		Armed For 1 X Yes	dent Ever in U. rces?	S. 13.	Yas Deced	fy Cubar	n, Mexican	, Puerto F	cify Yes or No- lican, etc.)	'	Black, White		
36	II, or	by F	3 ☐ Widowed 4 ☐ Divor		14 W O-		-54	1 Yes 2	№ No	Specify:				Specify: W	hite	
21215-0036	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f show It e McGreal Examiner mast be natified a	ted	15. Dece	dent's Educa	tion		16a. Dece	dent's Usual	l Occupa	tion	t of workin	a	16b. Kir	nd of Business/I	ndustry	
215		Completed	(Specify only his		College (1		life.	DO NOT us	e retired)		or working	9				
7	e filed within al Hygiene. I other than vent, It e Wo	Co	10	#= 1 = = A		0		asse			r's Name	(First, Middle, I		ircraft		
ng	₽ ₩ ₩ ₩	Be	17. Father's Name (First, Mid Alston W. Wa									Calbert		Sumame)		
Maryland	s 1 and 2 should be f f Health and Mental I item 27 is marked o other treumatic eve	2	19a. Informant's Name/Relat		Print)		19b. Maili	na Address	(Street a					Town, State, Z	ip Code)	
Ma	th an the and		Lois Walls -w		, , , , , , ,									Hagerst		21740
ē,	of Health of Health litem 27	. 3	20a. Method of Disposition			1 0	Place of Dispo emetery, crei	sition (Nam	e of			_		cation - City or 1		
9			1 ☑ Burial 2 ☐ Cremat '4 ☐ Donation 5 ☐ Othe		noval from S		st Hav				0/7/0	05	Hage	rstown,	Mary1	and
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Eugeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 15 E. Wilson Blvd., Hagerstown, Maryland 21740											.740		
			23a. Part1. Enter the disease shock, or heart failure.	o, or complica	tions that c	aused the deat									Approximate Interval Bet	9
	Physician		Immediate Cause (Final disease or condition	c,o: o, o		herosul	em513								Onsat and I	Death M-
	/Medical		resulting in death)	a		or as a conseq		,	1)				Malan	. ,
E	Examiner	_	Sequentially list conditions,	b.	Chy	unic C	4 struc	twe	Lu	25 0	11sca	15			Owiene	W
	ed isi	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or as a conseq	uence or):		,	•				ļ		
	ate be executed thysician and the burial-transit	xan	that initiated events resulting in death) Last	c.	Due to (or as a conseq	uence of):									
8760,	sician buris															
9	tificate ig phys as the	edic		<u> </u>												
Box	eath certifi attending for use as	M/us	IF FEMALE: 23b. Was decedent pregnan	230		come of pregna]Ectopic pre	egnancy				2	3d. Date of deli		Year
	ne death the atte	Physician/Medical	in the past 12 months?			ant at time of c		Other (sp						Month	Day ^	I Gai
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant cor	ditions contr	obuting to de	eath hut not res	ulting in the s	ınderivina ca	alise dive	en in Part I		23e. Did to	nacco u	se contribute to	the cause of c	leath?
Records,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by		antona conti	ibuting to de		and the contract of the contra		au 30 give	311111 4111	· 		es 2[1.		Jnknown
ecc	e law re has be je 2 sh	Completed										24a. Was a autops	v	24b. Were au prior to death?	topsy findings completion of c	available ause of
		Co										perfor	No	1 Tes	2□ No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to me examiner?		spital:		15D/0-1	nt 3□ DO	Othe	20		(Check only or		3 □Other (Spec	-:64)	
of	Phys ir this aral dii	.: To	1 Yes 22 No 27. Manner of Death		28a, Date	of Injury	28b. Time of		8c. Injury	/ at		8d. Describe h			ліу)	
lon	Attending I r death. ector: After by the funer	atio	1-E Natural 5 □ Pe 2 □ Accident in	nding restigation	(MON	th, Day Yeer)	Injury	М	Work 1 □ `	Yes 2	No					
Division	after des	Certification;	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	ould not be termined	28e. Place buildi	of Injury - At h ing, etc. (Speci	ome, farm, st	reet, factory	, office		2	8f. Location (S City or Tow		d Number or Ru)	rel Route Num	ber,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C			er: On the b									and manner as place, and due		;)
	To the To the To the Comple	Me	29b. Signature and title of ce	rtifier	1			130		number		2	9d. Dat	e signed (Monti		
	0, 18		plan 1+	we	4 M	0		D	005	678	55		Och	her 5	, 200	2
	D'3		30. Name and rociess of pe	ul Co	empl	se of death (Ite	Ste	130		gers	tow	n md	2	1740		
	Sta Regist		31. Date filed (Month, Day, 1	0 6 200)5 32. 5	egistrar's Sign	B. A	perke	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene O O C

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	•	1 - For State Registrar	State of Mary	/land / Dep Ce	artment of H rtificate of I	lealth and N Death		iene2 0 0 5	33491		
Physicia: /Medica	_	1. Decedent's Name (First, Middle, Last) STEPHONE	UGENE	WIGGINS	5		2. Date of Death September		3. Time of Death 12:30 A M		
Examine	r	4a. Facility Name (If not institution, give st Suburban Hospital	reet and number)		4b. City, Town, or Bethesda	Location of Death		4c. County of Death Montgomer			
Funeral Director		5. Social Security Number 6. Sex 1 1 2 1 2 1	7. Age (lr 4 2 F 2 3	n yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 13		nplace (State or Foreign		
show		Usual Residence of Decedent 10a. State 10b. County MD Month Communication		c. City, Town or L					10d. Inside City Limits 1X Yes 2 □ No		
with the M a or 28a-f Lbe notifie	Directo	MD Montgom 10e. Street and Number 18933 Red Robi		Germa	10f. Zip Code 208	7.1	10	Dg. Citizen of What Cor			
SI I	by Funeral Director		2. Was Decedent Ever Armed Forces? 1 — Yes 2 No ff Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amei Black, White			
i within 72 hou ione. I than "natura it has medical is	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12) 12th	ntion	(Give	dent's Usuaf Occupa s kind of work done of DO NOT use retired	during most of work	ing	Gibbs Col			
wild be filed Mental Hyg arked other atic event,	o ge	17. Father's Name (First, Middle, Last) Joseph Middl	eton Jr.				e (First, Middle, M	faiden Sumame)	.1090		
alth and 2 Sho		19a. Informant's Name/Relationship (Type Stephanie Freem				and Number or Run	al Route Number,	City or Town, State, Zo antown, M			
Pages 1 ament of He ant: If item ury grothe		20a. Method of Disposition 1 □ Burial 2 ♣ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	noval from State	20b. Place of Dispercemetery, cre-	osition (Name of matory or other place unr Svcs	θ)	Date 2	20c. Location - City or 1 Alexandri	Town, State		
permit. Departi Import any inj once.		21. Sign fun of Funeral Service Licens	Lower	/ 2	2. Name and Addres	ashingto	on St Ro	ockville.	Iome, P.A. MD20850		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one fmmediate Cause (Final disease or condition resulting in death)	cause on each line.	once I	ter the mode of dying				Approximate Interval Between Onset and Death		
	edicai Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or infury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d									
To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	FIIVE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	:. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of defiv	very Day Year		
w requires that s been signed be should be detailed.	ַ בַּ	Part II. Other significant conditions contr	buting to death but no	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribute lo	the cause of death?		
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sician certifi irector		25. Was case referred to medical examiner? ↑XOX'es 2 □ No	spital:	0.000	othe Othe		Check only one				
To the Hospital or Attending Physician: The twithin 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		f 28c. Injury	4 Nursing no	me 5 Resider 28d. Describe hov	7) -	ulted		
ital or Attanding Purs after death. rai Director: After illed in by the funera		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	POCIN	1		City or Town,	ade Dr. mo	na Rola		
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with To to Com	A	29b. Signature and fittle of centifier	W	4	O.C.M			d. Date signed (Month, ptember 25	•		
		30. Name and address of person who com	pleted cause of death	111	Penn Str	eet, Balt	imore,Ma	ryland 21	201		
State Registra		31. Date filed (Month, Day, Year) SEP 2 8 200	32. Registrar's S	Signature	ale						

4		Please Type or Print in Black Indelible Ink. Ensure A	-		
		State of Maryland / Department of Health and N	lental Hyg	giene nns	33492
		1 - State Amended 28c,9/29/05,LDB,DOR Certificate of Death 1. Decedent's Name (First, Middle, Last)		leg. No.	
Physici /Medi Examir	al	MARGARET D. WARD 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month	23 200 4c. County of Dec	5 8 AM
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Ars. Another Days Hours Min.	8. Date of Birth (Month, Day	DORCH 1921	rthplace (State or Foreign Jounty)
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		/	10d. Inside City Limits
the Mar 28a-f st	Director	MD DORChester CAMBRIDGE 10e. Street and Number 10f. Zip Code		10- 03: (14)	1 Yes 2 No
ath with	rai Dir			10g. Citizen of What C	,
and 21215-0036 be filed within 72 hours after death with the Maryland hat trygiene. Indicate then "natural", or liems 23a or 28a-f show evant, tre Medical Exercitiva matter multiplication.	y Funeral		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
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Maryland 2121 d 2 should be filed within th and Mental Hygiene. ?? Is marked other then." traumetic event, tre Me.	ompl	Elementary(Secondary (0-12) College (1-4or 5+) C/PRK TVD; S+		U.S. Gove	rnment
yland 2 ould be filed a Mental Hygie arkad othar atic evant, ii	Be	17. Father's Name (First, Middle, Last)	e (First, Middle, sie Jone	Maiden Sumame)	
arylan 2 should be and Mental Is markad o aumatic ev	T ₀	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			Zin Code)
re, Maryla s 1 and 2 should f Health and Men item 27 is marka othar traumatic		Robert Ward/Son 7401 Robin Road, La			
or He				20c. Location - City o	
Itimore, it. Pages 1 ar intment of Hea intent: If item injury or othal		14 Donation 1 Other (Specify) Our Lady of Good Counsel 9/27/	2005	Secretary,	Maryland
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fune al Service La ree 22. Name and Address of Facility. Zeller Funeral Home 106 Main Street, Ea	P. O.	Box 207 Market, MD	21631
Pnysician		e3a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of the death of the mode of dying, such as cardiac of the disease of the mode of dying, such as cardiac of the mode of dying of the m	or respiratory arr	est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):			")
bed size	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
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687 ifficate g phys as the	edic	d			
9.0. BOX 687 at the death certificate by the attending phys tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year
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Hec The law ate has b	Completed		24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
VIII eiciar certif recto	o Be	25. Was case referred to medical 26. Place of Death examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outnatient 3 DOA Other: Nursing Hou	-		
n of ng Phy fter this	ertification; To	27. Manner of Death 1. Anatural 5 Pending (Month, Day Year) 2 Accident investigation Pending 1. Pending 2. Accident North Pending 2. Accident North Pending 1. Pendin		ence 6 Other (Spe ow injury occurred	ecify)
DIVISIO	ertific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
To the Hospital within 24 hours a To tha Funaral (edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the ca ed at the time, di	ause(s) and manner a ate and place, and du	s stated. a to the cause(s)
To the within 2 To tha complet	Me	29b. Signature and title of certifier 29c. License number	3	9d. Date signed (Mont	*
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Crowley, M.D., 508 Idlewild Avenue, Easton, Ma	my 1 == 1 C	•	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ryrand 2	71001	
Registr	ar	SEP 2 9 2005 Bleene & Soule			

		1- For State Registrar		partment of Health and ertificate of Death	-	•	
Physici /Medic Examir	cal	Decedent's Name (First, Middle, La: SUSAN EVE WILK Aa. Facility Name (If not institution, give	INS e street and number)	4b. City, Town, or Location of Dea		Day Yea ber 26 200 4c. County of De	5 10:19A M
Funeral Director		Usual Residence of Decedent	iex	Months Days Hours Min	. (Month, Da		ry Birthplace (State or Foreign Country) shington DC
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sincipal and Mental Hygiene are stated to the than "natural, or iteme 23e or 28e-f ehow enty injury or other traumatic event, the Madical Examinar mantice notified at once.	Funeral Director	10a. State				10g. Citizen of What	-
hours after deatl	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒No Specify: 1 ☐ Yes 2 ☒No Specify:		Specify:	mencan Indian, nite, etc. White
e filed within 72 al Hygiene. I other than "nat vent, It a Medic	Be Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+) College	cedent's Usual Occupation ive kind of work done during most of wo be not not use retired) ancial Accounting 18. Mother's Na		Higher Edu Maiden Sumame)	,
and 2 should be eath and Menk in 27 is marked set traumatic er	To B	Ralph Louis Will 19a. Informant's Name/Relationship (Walter Geary, Hus	Type, Print) 19b. M. sband	Jean Lou ailing Address (Street and Number or R 207 Mowbray Road S	ural Route Numb	er, City or Town, State	
Definition Semit. Pages 1 Separtment of H. Important: If Iter my injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Removal from State Ft. Linc	sposition (Name of rematory or other place) oln Crematory 10-0 22. Name and Address of FacilityHir	es-Rinal	20c. Location - City of Brentwood. Idí Funeral	, MD Home, Inc.
Physician / Medical Examiner	Ilcal Examiner	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Myocardial Due to (or as a consequence of):	Infarction stinal Hemorrhage	c or respiratory a	irrest,	Approximate Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eliter death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of d Month	elivery Day Year
w requires that been signed to should be detailed.	Completed by Pi	Part II. Other significant conditions of	ontributing to death but not resulting in the	o underlying cause given in Part I.			Probably 4 Unknown
vician: The la certificete has rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:	0	autor perfo 1 Yes ath (Check only o	psy prior to death? 2 ☑ No 1 ☐ Ye	s 2 No
ittending Physical Actor After this the funeral dis	Certification; To	27. Manner of Death 1 Tanatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time Injur	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe l	dence 6 Other (Sp how injury occurred	
To the Hospital or Attending R within 24 hours elter death To the Funeral Director: After completely filled in by the funer.		4 Homicide determined 29a. Certifier 1 Certifying Ph	28e. Place of Injury - At home, farm, building, etc. (Specify) ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place	City or Tov		
	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Mor	
lo			completed cause of death (Item 23a) (Typ			September 2	20910
Sta Registr		Maria D'Arbela, 31. Date filed (Month, Day, Year) SEP 3 0 20	MD Holy Cross Hos	pital 1500 Forest	Glen Roa	d Silver S	pring MD

State of Maryland / Department of Health and Mental Hygien 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 64. Month **Physician** Gordon H. Wheatley 11:40 AM 520 ember /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Cambridge 306 West End Avenue Dorchester 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 6, 1927 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mary Land 217-20-3445 78 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show injury or other traumatic event, I'm Medical Exacting Interiors be notified at 1 Yes 2 No by Funeral Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 West End Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates:1945–1950 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours atter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced "natural". White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) 8 Mechanic Manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John H. Wheatley Florence Thomas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 West End Ave., Cambridge, MD 21613 Charlotte Hubbard Wheatley/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Spedden-SewardCemetery 10/01/2005 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Fromwel Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atter this certificate has autopsy performed 1 Yes 2 ☑ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D50804 September 28,2005 Ru, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge, MD Mark Malkus, M.D 408Byrn 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylan		artment of rtificate o				giene leg. No.2 () () 5	334	95
	Physici	an	1. Decedent's Name (First, Mi	iddle, Last)						2. Date of Dea Month	Day	Year	3. Time of D	eath
	Physici /Medio		Thomas	R.		Lson				Septem	ber 23 2	2005	0110	М
	Examir	er	4a. Facility Name (If not institu				4b. City, Town		n of Death		4c. County			
_			Anne Arunde L 5. Social Security Number	Medical Cent		last birthday)	Annap		er 24 Hrs.	8. Date of Birth	Anne			Foreign
	Funeral Director		216-30-1572	1 ∑ M 2□F	70	Yrs.	Months Day	s Hours	Min.	(Month, Day	, Year)		lace (State or F etry) Land	or orgin
	P.		Usual Residence of Decedent		40- 00									
	show	7	10a. State 10b. Cou		10c. Cit	ty, Town or Lo						1	0d. Inside City 1 ☐ Yes 2	
	the M	ecto	MD Ann 10e, Street and Number	e Arundel		Annapo	10f. Zip Code				l0g. Citizen of W	hat Coun		
	3a or	Funeral Director	1472 Breezew	good Court				1401			USA	nat oddri		
	deeth	nera	11. Marital Status	12. Was Decedent		.S. 13.	Was Decedent of If Yes, specify Ci		Origin? (Spec	cify Yes or No-	14. Race		an Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, it e Madical Examiner must be notified at once.	by	1 ☐ Never Married 2X h	Married 1 X Yes 2 ☐	10EE		1 ⊡ Yes 2 🕅 N			noan, etc.)	Specify:	, White, 6	hite	
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ary	shou and M s mar	-	19a. Informant's Name/Relati	onship (Type, Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Rural	Route Number	r, City or Town, S	State, Zip	Code)	-
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ı			· ·	o, or complications that cause List only one cause on each l	ed the death line.	h. Do not ent	er the mode of d	ying, such a	is cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Dea	en ath
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ă	death e atter d for u	Physician/M	in the past 12 months?	1 □ Live birth 4 □ Pregnant a			Ectopic pregnar Other (specify)				Mont		Day Yea	ar
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Division	or Attending after death. Director: After in by the fune	ertification:	3 ☐ Suicide 6 ☐ Cou	uld not be 28e. Place of In	njury - At ho	ome, farm, str	eet, factory, offic	в	28	f. Location (St	reet and Number	or Rural	Route Number	r.
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Amend item#5, per Pintin Black Indeline Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 24 2005 Ernest Wallace 5:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium @ South River Edgewater Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Unit 27) 5. Social Security Number 2282 6. Sex 157 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1927 1 1 M 2 □ F Maryland 78 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic avant. It is Medical Examiner must be notified at Maryland Anne Arundel Lothian 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5157 Solomon Island Rd. 20711 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ Xlo Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Construction 0 Jones Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic av 2008. Lloyd Wallace Lucy Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Wallace(Wife) 5157 Solomon Island Rd. Lothian, Md. 20711 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Church 10-1-05 Lothian, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. M00482 70 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably **Unknow**n Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 2□ No 1 Yes SXN funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760,

The law requires that the death certificate be executed the attending physician and hed for use as the burial-trae 2 cate has been signed page 2 should be det Division of Vital Records, certificate has Phyaician: this After Hospital or Attanding death. after death Diractor: within 24 hours a To tha Funaral L

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Items 23a

death

2 should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or Iter

Baltimore, Maryland 21215-0036

Medical (Check only one) 29b. Signature a

29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D57028

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

itya opramo, book 32. Regitrar's Signature

State Registrar

SEP 28 2005



State of Maryland / Department of Health and Mental Hygiene 005 33497 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. **Physician** Louise Waters 2005 5:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Ginger Cove Health Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Match Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🙀 F 92 215-03-5368 Yrs Director 1913 30, Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ehow. arment of Heath and Mental Hygiene. orient: if Nem 27 is marked other then "natural", or Itema 23a or 28e-1 shov njury or other traumatic event, "Le Medical Examinar must be notified at 1 ☐ Yes 2 K No Annapolis Directo Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 United States 1210 River Crescent Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3€Vidowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government 12 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If Item 27 is marked ott Be Louise Taylor John W. Stribling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11126 FM 3005 Galveston, TX 77554 Ann S. Crouch/ niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-26-2005 Baltimore Crematory Baltimore, MD permit.
Departr
Import 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athero Schnotic Physician Heart Disease /Medical Due to (or as a consequence of) Examiner Fai lune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed anding physicien end use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by should b 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physicien: After this certification, 25. Was case referred to medical 26. Place of Death (Check only of Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident s efter des. 5 ☐ Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeret D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ÷ ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26105 01 12010 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Bowie, MD 20715 (Gallant Fox Lane) Dr. Rakesh Arora 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State 27 2005 Registrar

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		Funeral Director		5.
	90036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, it a Medical Examinat must be notified at once.	To Be Completed by Funeral Director	10 10 11 11 11 11 11 11 11 11 11 11 11 1
CHAIR SOLL TAILE	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiena. Important: If item 27 Is marked other than "nat any fojury or other traumatic event, Ir a Media.	ro Be Complete	17
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1 - For State Registrar) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ²46 2005 Thomas David Wilkinson, Sr. September 0110 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Itospital Easton Talbot Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Davs Hours 1**X**M 2□ F Yrs. 56 212–26–0953 10-26-1948 Maryland sual Residence of Decedent 10b. County 10c. City, Town or Location Da. State 10d. Inside City Limits Maryland Caroline Preston 1 ☐ Yes 2 X No e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 Dover Bridge Rd. 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Tile Setter Construction 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Wilkinson Mary E. Williams 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Angela Wilkinson/ Wife 20910 Dover Bridge Rd., Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) a. Method of Disposition 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 9-30-05 * 4 ☐ Donatton 5 ☐ Other (Specify) Annapolis, MD 1. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 3a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ex SIS 1 day /Medical Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Ravs that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown led by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign(þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 24 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending death. investigation 1 Yes 2 No the f 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō

Division of Vital Records, P.O. Box 68760 within 24 hours a

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completely filled

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) 126/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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David Oliver, M.D.

2397

State Registrar

Medical

31. Date filed (Month Day, Year) SEP 2 7 2005



		•	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of Hea	lth and Mental Hy ath	ygien 005	33499
ı	Physici		1. Decedent's Name (First, Middle, La Margaret Wrigh	•			2. Date of D Month Septem	nber 25 20	3. Time of Death
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural, or Itema 23a or 28a-f show any fujury or other traumatic event, I'm Madicul Exarting ment for invitilied at ance.	Completed by Funeral	102 N. Crain F 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN		21061 Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	USA lo- 14. Race - Am. Black, Whi	
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altimore,	Pages 1 ment of Ha ant: If Iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of Control		20b. Place of Dispo Mænewely, ær	osition <i>(Name of</i> refor Vieweren etery	9-30-05	20c. Location - City or Crownsvil	
Balt	permit. Departimport Import any inj		21. Signature of Funeral Service Lice	nsee 7	MO0482 8	Name and Address of Reese	Sons Mort	cuary, P.A	401
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C							
)	To th within To th	Me	29b. Signature and title of certifier	For .		29c. License nur	mber 4 804	29d. Date signed (Moni	th, Day, Year)
			30. Neme and address of person who				c to	- 12cf	11/2000
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State of Maryland / Department of Health and Mental Hygiene 33500 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Joanne Watson September 23, 2005 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 600 Small Reward Road Calvert County Huntingtown If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 5. Social Security Number 7. Age (In yrs. last birthday) Under 1 Year onths Days Birthplace (State or Foreign Country) **Funeral** 1934 Hours Min Months 1 □ M 2 X F Washington, DC Director 578-42-4595 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland hent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, the Modeal Examinar must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director MD Calvert County Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 600 Small Reward Road 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Dale Hulvey 2 Katie Mae Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
eny injury or other treu 600 Small Reward Boad, Huntingtown, MD 20639 ce of Disposition (Name of netery, crematory or other place)

Sept. Data 4, George H. Watson (Husband) 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory
22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

MD 20736 2005 21. Signature of Funeral Source 24 Michael W. Leely 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Physician cancel ica is /Medical Due to (or as a consequence of). Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical as the b IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown by cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 [] No 1 ☐ Yes 2 No 1 TYAS or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 061 September 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Patel, M.D. 31. Date filed (Month, Day, Year) 110 Hospital Road, Prince Frederick, Maryland 20678 32. Registr State SEP 2 6 2005 Registrar